Dear Colleagues,

Paper 2/2017: Adult Social Care

Adult social care is clearly a very timely issue for the CPF to consider: it has been featured several times in the news recently and the subject seemed to be at the top of councillors' agenda at a recent conference organised by the Conservative Councillors Association—indeed, I think it was highlighted in every session that I attended!

The closing date for responses to this discussion paper is 7 May. We look forward to receiving your responses to this paper via the online response form or by email to CPF.Papers@conservatives.com in due course. A summary of all responses will be considered by the CPF Chairman, George Freeman MP, who will take the best ideas and suggestions to the PM's Policy Board and Government Ministers.

The next paper will be on Skills and Training for a 21st Century Workforce and will be published after the elections in May.

With best regards,

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One-Page Summary

> *"There's no doubt about it, adult social care is a huge challenge for the public sector right now. People are living longer, and that inevitably means greater demand for care services. Every year you spend more than £14 billion on adult social care. It's one of the biggest cost pressures facing councils. The last Spending Review put in place up to £3.5 billion of additional funding for adult social care by 2019 to 2020. But I recognise that more needs to be done."* ***Communities Secretary Sajid Javid, Local Government Association Councillors' Forum, 19 January 2017***

> *"One of the things that has struck me as I've been doing this role is that nobody ever questions the fact that we look after our children — that's just obvious. Nobody ever says it is caring responsibility. It's just what you do. I think some of that logic and some of way we think about that, in terms of the sort of volume of numbers that we are seeing coming down the track, will have to impinge on the way we start thinking about how we look after our parents."* ***David Mowat, Care Minister, Commons Local Government Select Committee, 30 January 2017***

Health and social care services are facing two major population challenges: an ageing population and a rising life expectancy that is not matched by an improvement in healthy life expectancy. The effect of this population shift on health and social care services is significant.

Topics for discussion

1. Integration
2. Carers

   International Case Study: Singapore
3. Accommodation
4. New technology

   International Case Study: US Department of Veteran Affairs (VA)
5. Funding

   International Case Studies by the Kings Fund
6. Regional challenges

Appendix: International Case Studies **–** Sweden and Australia

> *"There's no doubt about it, adult social care is a huge challenge for the public sector right now. People are living longer, and that inevitably means greater demand for care services. Every year you spend more than £14 billion on adult social care. It's one of the biggest cost pressures facing councils. The last Spending Review put in place up to £3.5 billion of additional funding for adult social care by 2019 to 2020. But I recognise that more needs to be done."* ***Sajid Javid, Communities Secretary, Local Government Association Councillors' Forum, 19 January 2017***[1]

> *"One of the things that has struck me as I've been doing this role is that nobody ever questions the fact that we look after our children — that's just obvious. Nobody ever says it is caring responsibility. It's just what you do. I think some of that logic and some of way we think about that, in terms of the sort of volume of numbers that we are seeing coming down the track, will have to impinge on the way we start thinking about how we look after our parents."* ***David Mowat, Care Minister, Commons Local Government Select Committee, 30 January 2017***[2]

Introduction

Health and social care services are facing two major population challenges: an ageing population and a rising life expectancy that is not matched by an improvement in healthy life expectancy.[3] Over the last 60 years, life expectancy has increased by 12.6 years for men and 11.3 years for women, to 79.0 and 82.8 years, respectively.[4] Disability-free life expectancy[5] is rising more slowly than life expectancy, however, meaning that people are living for more years with disabilities. Moreover, the gender difference in life expectancy suggests that most of the extra years of life for women are years with disability or ill-health.[6]

The effect of this population shift on health and social care services is significant. People with long-term conditions account for 29 per cent of the population, but use 70 per cent of all inpatient bed days.[7] Over-75s use more than 60 per cent of bed days in acute hospitals and 70 per cent of the health and social care budget is spent on chronic conditions.[8] Increasing demand is one of the key factors causing funding gaps, originally estimated at £30 billion in the NHS and £4.3 billion in social care by 2020 in England alone.[9] Yet, lifestyle behaviours—such as exercise, healthy diet, not smoking, and consuming low amounts of alcohol—have large effects on the risk of developing chronic diseases and dementia in later life.[10] Older people are likely to require both health and social care to meet their needs.[11]

Two-in-three people who die are aged over 75. Most of these deaths come after a period of long term illness such as heart disease, cancer or dementia. Three-out-of-four people say they would prefer to die at home. Although the number of people dying at home has recently increased, over half of deaths still occur in hospitals.[12]

What next? Questions for discussion

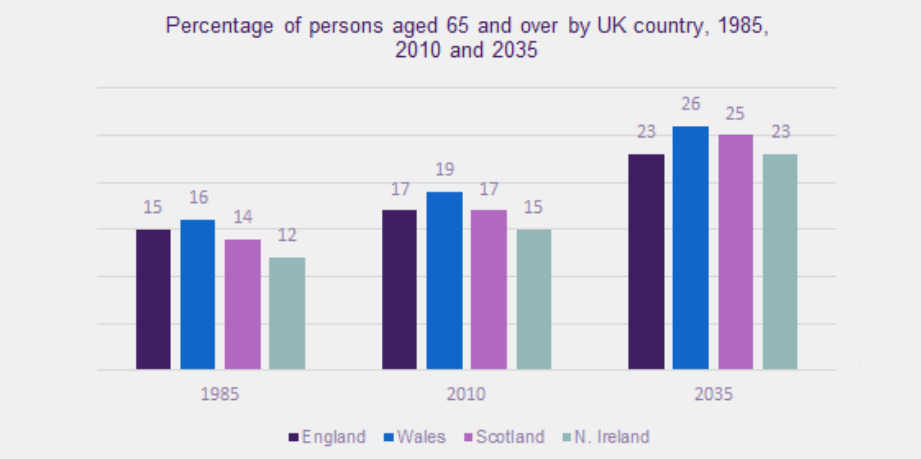
a. How might the Government seek to encourage healthier lifestyles, so as to reduce the burden of chronic disease and the demand for social care in later life?

1. Integration

> *"If we truly want to change from a bureaucratic to a patient-centric system, the NHS needs a profound transformation in its culture. 'Patient-centric' is a horrible phrase. How about 'more human' - the title of Steve Hilton's recent book? Because the truth is that decades of building processes around system targets and system objectives, often with the best of intentions, has demoralised staff and patients and dehumanised what should be some of the most human organisations we have. … As Steve says, too often 'patients have become outputs, their health outcomes, products; our hospitals, factories'."* ***Jeremy Hunt, Health Secretary, 16 July 2015***[13]

An ageing population and the increasing prevalence of long-term conditions are putting pressure on health and social care services. For too long, the NHS dealt with people's health needs and local authorities with their social care. All too often they did not work well together, resulting in people having to go to hospital unnecessarily and staying there for longer than necessary because there was inadequate support for them at home. Thousands of people who found themselves having to pay for care saw their savings wiped out or had to sell their homes.[14]

The four UK nations have committed to better integration between health and social care as one solution to these challenges.



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency[15]

In 2015 NHS England launched its *Vanguard* programme to promote radical redesign of care services. Emerging evidence indicates that these partnerships between the NHS, local government, and voluntary, community and other organisations are improving the healthcare people receive, preventing ill health and saving funds. For instance, Fylde Coast Local Health Economy's new "extensive care service" has seen a 37 per cent fall in planned visits to hospital and 13 per cent reduction in A&E attendances among patients receiving support.[16] Similarly, the Wakefield Vanguard Care Homes scheme recorded a 26 per cent reduction in bed days and 19 per cent reduction in emergency admissions.[17]

What Conservatives in Government have done so far

- Brought the NHS and local authorities together, so they can plan the best care for people in their own homes. The £5.3 billion Better Care Fund supports and promotes joint plans between the NHS and local authorities so they can work together better to look after people properly in their community.[18]
- The government has made six commitments to the public to end variation in end-of-life care across the health system by 2020.[19]

What next? Questions for discussion

b. As a society, how could we better align health and social care?

c. How might Government facilitate a shift in healthcare culture towards one that is more "patient-centric" or "more human"?

2. Carers

> *"There is a considerable cultural shift required for some people who offer care and support for adults with learning disabilities – both staff and carers. The previous model of offering a protective environment for people with learning disabilities may have kept people safe but has also led to some people being institutionalised and limited in their life opportunities. Staff need to be helped to understand how people can be supported to live a more independent life through being exposed to challenges and risks which can be safely managed."* ***Local Government Association, September 2016***[20]

Around 1 in 8 adults (6.5 million people) are carers. This represents an increase of 11 percent in just 10 years. By 2037, it is anticipated that the number of carers will increase to 9 million—a further rise of 40 percent. Carers are estimated to save the economy £132 billion per year, an average of £19,336 per carer.[21]

International Case Study: Singapore[22]

In Singapore, the Government encourages greater involvement in the care of relatives through various measures:

- Aged Dependent Income Tax Relief is given to children or grandchildren for the maintenance of their parents or grandparents.
- Grandparent Caregiver Tax Relief enables working mothers whose child is being cared for by his or her grandparents to claim annual tax relief of S$3,000.
- The Maintenance of Parents Act (passed in 1995) is a preventive policy to ensure that children provide financial support for their aged parents.
- The Multi-Tier Family Housing Scheme encourages co-residence by giving priority allocation for public housing to extended-family applications.
- The Joint Selection Scheme encourages close-proximity living of the generations by allowing parents and married children to have priority in selecting separate public flats in the same estate.
- The Central Provident Fund (CPF) Housing Grant is available to married first-time applicants who buy a resale flat from the open market near their parents' house.

More than a million older people in England now have at least one unmet need for social care, compared to 800,000 in 2010; this means they receive no help from their local authority or from family, neighbours or friends. It would cost an extra £4.7 billion in 2020/21 to provide a social care service to every older person with an unmet social care need, and only a little less to provide a service for those with three or more currently unmet needs.[23] Social isolation and chronic loneliness have a significant impact on health and wellbeing, increasing the use of health and adult social care services by older people.[24]

What Conservatives in Government have done so far

- The Care Act 2014 means that carers will now be given the same recognition, respect and parity of esteem with those they support.[25]
- Given new rights to carers so people looking after others get better support. The Care Act 2014 changed the law so local authorities have to assess carers for help. Breaks for carers are also being funded, as a respite from their caring responsibilities.[26]
- Over £400 million to enable 24/7 treatment in communities as a safe and effective alternative to hospital.[27]
- The council tax surcharge on self-contained family annexes was removed in 2014 by introducing a new national discount to encourage extended families to stay together and protect independence and dignity for all ages.[28]
- The community infrastructure levy on self-build properties was also removed in 2014, including all extensions, family annexes and home improvements.[29]

What next? Questions for discussion

d. Should the Government incentivise the NHS more to support adult care, or does the responsibility lie elsewhere? Could—or should—we be incentivising people who can be doing more in their community, or is that an old-fashioned approach? How might we help and support society and community groups to look after themselves more, tackling social isolation and providing informal care?

e. What policies might the Government introduce or pursue to empower, equip and encourage individuals and families to provide care and support for relatives and others in their communities?

3. Accommodation

Long-term care is provided by voluntary organisations, local councils, health authorities and private agencies and there are three types of institutional care: residential care homes, nursing homes, and long-stay hospital provision. Additionally, sheltered housing provides opportunities for older people to live independently within a small community and to access help and support when required. The rather fragmented nature of the care home market combined with the fact that local authorities are the largest single purchasers in most parts of the country, means that local authorities have what has been described as "monopsony" purchasing power.[30] Approximately 80 per cent of the non-residential care demand comes from public settings, while approximately 90 per cent of the residential care demand comes from private settings. Both are forecast to increase by about 20 per

cent per decade to at least 2040. Many public companies were taken private in early 2000 because of poor market conditions.[31]

Several years ago, a national evaluation estimated that investing £1.61 billion annually in housing-related support services generated net savings of £3.41 billion for the public purse, including an estimated saving of £315.2 million in health service costs.[32] A trial project in the north east between a housing association and two clinical commissioning groups worked with GPs to prescribe double glazing, boilers and insulation to patients with health conditions exacerbated by living in a cold damp home. The *Boilers on Prescription* project reported a 60 per cent reduction in the number of GP appointments needed and a 30 percent reduction in attendances at A&E by people taking part over the 18 months of the trial.[33]

The *Healthy New Towns* programme[34] is working alongside ten new NHS-supported housing developments across the country to offer challenge, inspiration and support as they develop their plans for building healthy communities. They are exploring how sites can redesign local health and care services, and how they can take a cutting-edge approach to improving their community's health, wellbeing and independence. The NHS is bringing together renowned clinicians, designers and technology experts at these sites to deploy new models of technology-enabled primary care and to showcase what is possible by joining up design of the built environment with modern health and care services.

What Conservatives in Government have done so far

- Explicitly referenced housing in the Care Act 2014 as part of local authorities' new duty to promote the integration of health and care; and included the suitability of living accommodation in the definition of the core wellbeing principle, which local authorities are required to promote.[35]

What next? Questions for discussion

f. Are there any new features that could be incorporated into new housing developments that could assist with social care?

4. New technology

"Assistive, intelligent robots for older people could relieve pressures in hospitals and care homes as well as improving care delivery at home and promoting independent living for the elderly. It is not a question of replacing human support but enhancing and complementing existing care."
Irena Papadopoulos, Professor of Transcultural Health and Nursing, Middlesex University, 30 January 2017[36]

"Despite almost 60% of adults in the UK owning a smartphone we know only 2% of the population has had some kind of digitally-enabled interaction with NHS. The range and sophistication of technologies offers us the potential to provide a more tailored and patient-centred approach to care. Simple use of SMS messages can remind patients about appointments, medication and self-testing as well as allowing them to instantly update their records on key vital signs such as blood pressure or glucose levels." ***George Freeman, Minister for Life Sciences, 3 September 2015***[37]

"Imagine the degree of personal control that could be afforded by a smart phone configured for medical applications, coupled with wearable biosensors and capable of sensing, analysing and displaying vital signs and alerting you and your clinicians to significant changes or deterioration wherever you are, rather than through check-ups at a hospital or GP practice. Any escalation in a condition could be identified and addressed in a timely and proactive way. It would lead to better health outcomes while being more convenient for the patient, their carer and their clinician. This is the future of healthcare. Twenty years from now, we will use technology to access our health services as a matter of course. That future is fast approaching as technologies constantly evolve, adapt and improve." ***Professor Sir Bruce Keogh, NHS England's National Medical Director, 23 September 2014***[38]

High-tech automated robots already play a key role in the dispensing and storage of pharmacy medicines in hospitals [39] and robotic-assisted surgery is commonly used for prostate, bladder and kidney removal.[40] Now researchers are exploring the development of culturally aware robots aimed at assisting in caring for the elderly.[41]

International Case Study: US Department of Veteran Affairs (VA)[42]

Annual health care expenses between 2009 and 2012 for veterans treated via telehealth decreased by 4 per cent one year after beginning the use of such services. In 2013 alone, VA-specific telehealth applications delivered care from 151 VA medical centres and more than 705 community-based outpatient clinics. Of the 608,900 veterans who were treated via telehealth, 45 per cent lived in rural areas. In total, nearly 1.8 million episodes of care used telehealth services. The number of veterans receiving telehealth care is increasing by about 22 per cent each year.

In addition, the study found that in 2013:

- Home telehealth services reduced bed days of care by 59 per cent;
- Home telehealth services reduced hospital admissions by 35 per cent; and
- Clinical video telehealth services reduced bed days of care for mental health by 38 per cent.

Technology Enabled Care Services (TECS) have the potential to transform the way people engage in and control their own healthcare, empowering them to manage it in a way that is right for them.[43] Telecare technology, such as personal alarms, is already helping more than 2.2 million people across the UK to live independently and to stay in control of their own health and wellbeing.[31] Telehealth is less mainstream than telecare at present but is growing, typically for specific hospital services and medical conditions.[44] Examples include home-based monitoring units that send medical information such as blood pressure or blood sugar levels for clinical review at a remote location via a phone line or wireless technology. The largest randomised control trial of telecare and telehealth showed that such technology can deliver a 15 per cent reduction in A&E visits, a 20 per cent reduction in emergency admissions, a 14 per cent reduction in elective admissions, a 14 per cent reduction in bed days and a 45 per cent reduction in mortality rates.[45] The study found less evidence that telehealth will save money[46] but the costs have reduced since the trial, changing the cost-benefit trade-off,[47] and the Department of Health estimates that savings from the widespread use of telecare and telehealth could save the NHS up to £1.2 billion over five years.[48]

What Conservatives in Government have done so far

- The UK Government has identified Life Sciences and Healthcare as important sectors both to generate new economic growth and to increase the quality of care for patients within the NHS. Academic Health Science Networks (AHSNs) have been established to connect academics, the NHS, researchers and industry to accelerate the adoption and diffusion of innovation, helping both to catalyse economic growth and to drive improvements in the quality and efficiency of care.[49]
- A three-year programme (DALLAS) managed by the Government's innovation experts Innovate UK worked with healthcare users and professionals to develop the tools the users need to look after themselves better, stay in good health for longer, and reduce their reliance on health and social services. New products now being used in the health and care system include a memories smartphone app that was co-designed by people with dementia and their families.[50]
- The Government backed the award-winning Inclusive Technology Prize, which was designed to inspire technological innovations in assistive products, systems and aids and encourage co-creation with people with disabilities.[51]
- The Government supports research such as the Engineering and Physical Sciences Research Council's assistive technology, rehabilitation and musculoskeletal biomechanics action plan, including the development of disruptive technologies for use in hearing aid devices.[52]

What next? Questions for discussion

g. What more should the Government do to promote and encourage greater use of the growing range of innovative technology that can help with assisted living?

5. Funding

Adult specialist care is the second largest health and care market, after older care, worth £10.1bn in 2015/16 in the UK (England: £8.5bn). Approaching 90 per cent of these services are outsourced to the independent (mainly for-profit) sector. It covers working-age adults with learning disabilities, mental health conditions, physical and sensory disabilities, acquired brain injury, cognitive and memory disabilities (including early onset dementia) and substance misuse:[53]

Learning disabilities	£5,800 million
Physical and sensory disabilities including Acquired Brain Injury (ABI)	£1,900 million (of which ABI care home rehab is £220m)
Substance misuse	£1,200 million
Mental health needs	£1,200 million
Memory and cognition disabilities	£100 million

Each year, councils are experiencing around 3 per cent growth in demand from new service users who have a learning disability or are within the autism spectrum requiring help and assistance. The costs of care, especially residential care, are much higher for this group than people with similar needs from other groups, e.g. older people with dementia care needs. This is the case even when the services are provided by charitable organisations and other not-for-profit companies.[20] Estimates suggest that councils paid an average residential care fee of £486 per week in 2016-17—£104 per week below the "floor" level of the Care Cost Benchmarks.[54]

The Local Government Association estimates that adult social care faces a funding gap of £1.3 billion by the end of the decade.[55] The adult social care market is now beginning to impact both on the people who rely on these services and on the performance of NHS care. This is translating to increased A&E attendances, emergency admissions and delays to people leaving hospital, which in turn is affecting the ability of a growing number of trusts to meet their performance and financial targets.[56] It is worth noting that, unlike social and community care services provided by local authorities, NHS Continuing Healthcare—a package of care for people who have significant ongoing healthcare needs—is provided for free.[57]

International Case Studies by The Kings Fund[58] – *See appendix*

The NHS is unique in its low level of cost sharing. Of nine international health systems profiled by The Kings Fund, including universal systems that are considered comprehensive such as Sweden and France, all charge users fees. These include co-payments for each visit to a health professional, a per day charge for hospital stays, prescription co-pays, deductibles or coinsurance whereby individuals cover a set proportion of their health care costs. In addition to raising revenue, user charges can be used to manage levels of demand, the location of care or choice of treatment/drug. For example, a lower charge for a GP visit compared with a visit to the accident and emergency department can encourage patients to seek care outside of the hospital. Most countries provide means-tested assistance to help those with low incomes meet their cost-sharing obligations, and in some countries private insurance policies are commonly held to cover these costs. While some countries have sought to decrease individual's cost-sharing obligations in recent years (e.g. Germany), the principle of paying at least a small fee for each use of the health service is not controversial in other countries.

What Conservatives in Government have done so far

- Capped care costs and extended support to more people so the system is fairer and people have more certainty about the future. From April 2020, there will be a cap on care costs of £72,000.[59] People will get support if their assets are worth less than £118,000 and the option of deferred payment will mean no one should have to sell their home in their lifetime.[60]
- Supporting councils to protect social care services in their community. Net current expenditure on social care increased from £20.962 billion in 2009/10 to £22.089 billion in 2014/15. We have given local councils £7.2 billion to protect social care services.[61] Government has made available up to £3.5 billion extra funding for adult social care during this Parliament.
- Government has empowered councils to increase council tax by 2 per cent a year for three years to pay towards social care in their areas, if they wish, with the flexibility to raise the precept by up to 3 per cent in 2017/18 and 2018/19. We have also allowed local government to retain savings from reforms to the New Homes Bonus to provide a new dedicated £240 million Adult Social Care Support Grant.[62]

What next? Questions for discussion

h. How might councils seek to improve outcomes and efficiency in services for adults with learning disabilities? How could they challenge the service to help people to aspire better to greater independence?

i. As a society, and as individuals, how should we fund and provide adult social care for an ageing population? What should the balance be between national and local taxation in funding social care? Is it fair that the next generation bear the cost or do we need a new inter-generational contract? How might we best strike the right balance between central state, local government and the family's role in tackling adult social care?

6. Regional challenges

A. Just 21 local authorities account for more than half of all social care delayed discharges and there is a 25-fold difference between the best-performing 10 per cent and the worst-performing 10 per cent, so we need to make sure that the health and care system learns from the best performers to raise standards across the system.[63]

In his address in January 2017 to the Local Government Association Councillors' Forum, Communities Secretary Sajid Javid said:

> *"I know that most of the delays are down to the health service. But a gap that size also has to involve some councils simply doing things better than others. Look at Southampton. It has reduced delayed transfers of care and unnecessary hospital admissions by integrating 7 health and social care teams into a single service under a pooled budget. If you're tempted to shake your head and say 'that's great, but things are different in the south', look at Northumberland. £5 million saved thanks to the council working with the local health trust. Demand for residential care cut by 12%.*
>
> *"And those statistics aren't just numbers on a balance sheet. They mean more people managing their own health. More people able to live independently in their own homes. More people recovering with their families in familiar surroundings rather than being marooned on a hospital bed. More efficient working is good for councils, good for taxpayers, and good for the people who matter most – those on the receiving end of services."*[1]

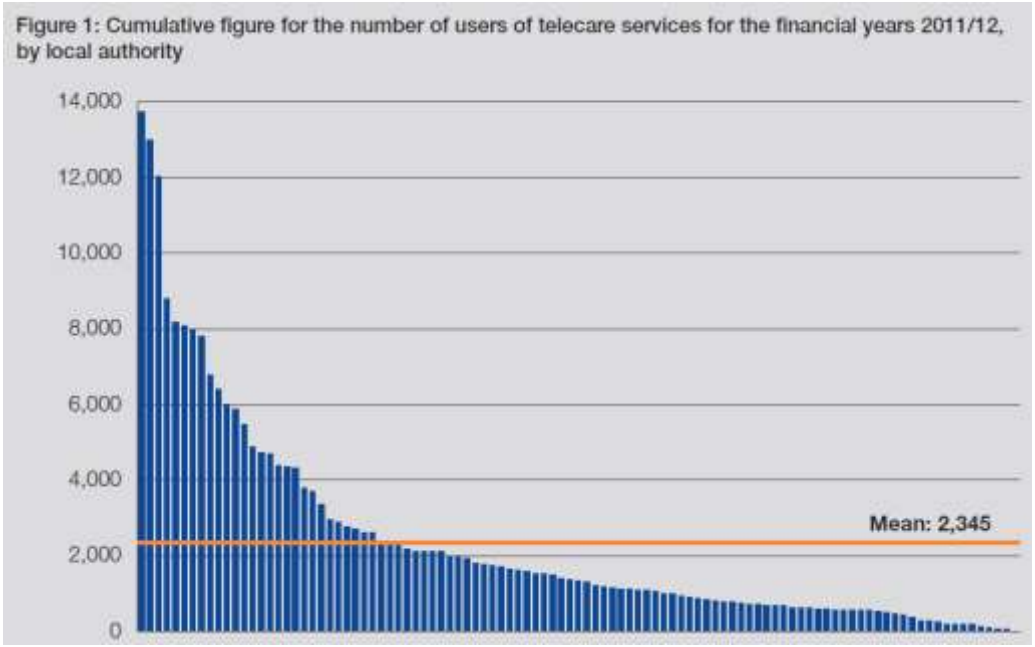
B. A means-test is applied to care home residents to determine if they are eligible for support from their local authority. In September 2014, there were 89,000 self-funders in residential care homes and 136,000 whose place was funded by local authorities.[64]

The *Financial Times* has noted that "The care home market is highly polarised between lucrative self-pay homes, mostly in southeast England, and those with local government-funded residents, which are struggling."[65] The pool of self-funders varies across the country:[66]

South East	54%
South West	49%
East of England	45%
East Midlands	43%
Yorkshire and the Humber	42%
West Midlands	39%
North West	36%
Greater London	30%

Scotland	30%
Wales	24%
North East	18%
Northern Ireland & Isle of Man	16%
United Kingdom	**41%**

C. Telecare services are normally procured by local authorities as part of social care packages and research suggests that most local authorities (about 53 per cent in 2013) are willing to invest in telecare, although there are some regional differences in the budget they are able to dedicate. For example, Sheffield City Council reported to have 12,015 people using telecare services in 2011/12, while Swindon Council reported having just 75 users.[67] Similarly, 61 per cent of Clinical Commissioning Groups were commissioning telehealth services in 2013/14.[68]



N.B. Powers over health have been granted to the devolved national Parliament and Assemblies.

What next? Questions for discussion

j. How should Conservative policy locally and nationally be influenced by the adult social care challenges that are particular to your area?

Resources

- **Housing, care and health infographics**: The King's Fund and the National Housing Federation have produced a set of slides illustrating the connections between housing, social care, health and wellbeing: link

People to seek opinions from

- Local Councillor with portfolio for adult social care and health
- Local MP

Appendix: International Case Studies – Sweden and Australia

Sweden

Sweden provides universal and comprehensive coverage of social care to all citizens. Decision-making powers are held at the local level. Needs assessments are conducted by municipalities and the level of help provided is based on factors such as functional limitations, age, and whether someone lives alone. There are limits on the maximum amount individuals can pay out-of-pocket for their care needs, and the level of co-payments is income-related. Residential care is provided for varying levels of need. Coverage includes accommodation and daily living costs, but users make a contribution based on their income. A significant amount of care is provided by informal carers and some municipalities reimburse informal carers for some of this through "relative care benefits". The maximum charge per month for home help was around £165 in 2011.

Long-term care expenditure is mostly financed through local taxation at the municipal level (85 per cent) and some national government grants (11–12 per cent). Private out-of-pocket spending is low compared with other OECD countries, making up just 3–4 per cent of total expenditure. Residential care facilities ("special housing") are run by private companies commissioned by municipalities. Individuals have the choice of receiving home help from public or private providers. The number of private home help companies is increasing and in 2011 19 per cent of older people receiving home help got their care from private providers.

One of the biggest reforms to the system in recent years has been the introduction of choice and competition into the home health sector in an attempt to improve quality. Older people can choose an accredited home care provider from the public or private sectors. There has also been extensive use of financial incentives to promote improvement in the social care sector. Since 2010, central government has included performance targets that are based on outcomes for older people's care into the annual transfer payments they make to municipalities. Although choice in social care has been shown to improve patient satisfaction, the impact of these new initiatives on quality and efficiency is not yet known.

Australia

Australia's social care system is not universal and government assistance focuses on those with low incomes. The services provided are based on an assessment of an individual's need, and charges are determined by a means test. A range of services are offered by national and local government. These include residential care; community care packages for those who are eligible for residential care, but prefer to stay at home; and home and community care (HACC), a lower level of support, often for less than two hours a week, that includes cleaning and personal care.

In residential care, individuals make a means-tested contribution to their care costs, and pay accommodation costs and daily living expenses themselves. Regulations define a maximum amount each person can be charged for accommodation, based on their assets, and a maximum daily living charge. In low-level residential care, residents can be asked to buy an accommodation bond to cover their accommodation costs, which is effectively an interest-free loan to the residential provider. In 2009/10 the average cost of high-level residential care was £850 per week and the average recipient paid 26 per cent of that cost themselves. In low-

level residential care user contributions are higher; on average individuals pay half of their costs themselves. Users pay less of the cost of their community care, between 4 and 10 per cent on average, depending on the type of package delivered. The government covers the full cost of HACC services and since 2012 there has been an option for individuals to receive a personal budget and tailor the service to their own needs.

Community and residential services are rationed by limiting entitlement approvals and operating waiting lists. There is a maximum number of people who can receive care services at any one time, based on a set proportion of the at-risk population. HACC services are prioritised within a set budget based on need. Non-profit organisations are the main providers of residential care (59 per cent of beds), a third (35 per cent) is provided by for-profit providers and just 6 per cent by national and state governments. Community care is also predominantly provided by non-profit organisations (more than 80 per cent) with a small amount of for-profit and government provision.

Options for future funding of older people's care

Concerns about ongoing financial stability mean it is likely that user contributions will increase in the near future. The Australian Productivity Commission's Inquiry into Aged Care investigated three different options for the future funding:

1. Encourage working-age individuals to save money during their working lives to pay for care in older age, either via private savings accounts or superannuation. One problem with this approach is the unpredictable nature of long-term care costs. Most people will have moderate care costs and will save more than is needed to cover them. A small number will have very high care costs, but these are likely to be the people least able to save, so they are unlikely to have enough money to pay for their care. Consequently, the Commission viewed the ideal policy solution as one that protects people from high social care costs, while encouraging them to save money during their lifetime to cover normal/predictable costs of long-term care.

2. A home equity release scheme in which new financial products are developed to allow older people to draw on the equity in their homes to pay for care. As many people already save during their lifetimes through buying a house (83 per cent of Australians aged over 65 own or are buying their home), freeing up this money to pay for social care could solve the funding problem without crowding out incentives to save for other things earlier in life. Home equity release schemes already exist in Australia but are not widely used. They can be complex, with high interest rates and fees, and are vulnerable to changes in property prices and interest rates. The Commission recommended the establishment of a public equity release scheme which would build public confidence in these financial products, reduce the risk of exploitation and, by operating at scale, reduce the administrative costs of providing these products.

3. Long-term care insurance policies. The Commission felt that ideally the government or insurance companies would play a role in redistributing money from low- to high-intensity users. However, it concluded that voluntary long-term care insurance was unlikely to be financially workable, and due to the ageing population it is now too late to establish a compulsory insurance system that would collect enough money from the working-age population to cover the increasing care needs of the ageing population.

Endnotes

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