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Background Paper

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wanless social care review

Funding Options for Older People's Social Care

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FUNDING OPTIONS FOR OLDER PEOPLE'S SOCIAL CARE

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Introduction

There are many options for financing social care in old age, varying the balance between the state and the individual in terms of responsibility for funding. The choice of a financing regime will significantly affect the number of people receiving social care and the amount of social care that is likely to be commissioned. Different funding arrangements will also influence the level of demand; for example, more people are likely to ask for services that are free than for services that incur charges. Funding systems can also influence the way in which the care system decides who receives social care; for instance, England's current needs eligibility criteria are based on a broad-ranging, individual-focused assessment, whereas private insurance payouts are usually linked simply to the number of 'activities of daily living' (ADL) failures. Thus financing options need to be considered in the context of the overall principles and goals of social care.

This Background Paper augments and expands on subjects covered in Chapter 12 (Changing the Way the System is Funded), and is structured to be read in parallel with the main Review report.

Trends in other countries

In striving to meet the costs of long-term care, governments around the world have made very different decisions about where and how to draw the line between public and private responsibility. The choice of funding strategy tends to emerge from a combination of political inclinations and cost considerations. Ikegami and Campbell (2002) use an illustrative vignette to show the issues that underlie financing decisions. It is probably agreed, they argue, that an impoverished old lady living alone should be supported by the state. But what if her husband is alive and healthy? What if she has savings or assets? Should she expect to be able to leave an inheritance? If her children are well-off, should they contribute to care costs? Should the children be expected to provide some hands-on care? If formal services are provided, will informal carers withdraw their support? And what are the wider financial costs of relying on informal carers in terms of their economic role in society? The answers to these questions will have a bearing on what funding mechanism is preferred. Governments around the world have made different choices about how to address these issues.

This section provides further information relating to Chapter 12 (Section 2) in the Review, which looked at the trends in social care funding around the world.

State funding systems tend to fall into two categories (although there can be hybrids, such as in Japan): systems funded from general taxation and social insurance programmes. Even after the decisions about what *type* of system has been made, the decisions about needs and financial eligibility then have to be made in all systems.

There are pros and cons to both systems. The general arguments are outlined here, bearing in mind that the nuances of the many possible variants systems will affect any specific assessment.

Systems funded from general taxation

These may include an explicit entitlement to services (Austria, France) or, alternatively, eligibility may be through a needs assessment that is focused on the individual's particular circumstances, including access to informal care (England). For those deemed eligible for help, a tax-funded system can finance social care that is universally available regardless of wealth (for example, in Austria, Sweden, France), or one that is subject to a means test which determines eligibility for state support (England, Australia). The level of disability at which services are offered, and the amount of services provided, will depend on available resources. Following all the assessment processes, the government agency is usually tasked with arranging the appropriate services, although a cash payment may be available instead, as in England and particularly Austria.

Potential advantages

With a tax-based system, expenditure is matched against available resources. There are various potential advantages.

- A tax-based system which is based on individual assessments may be more efficient than one using explicit (algorithmic type) eligibility criteria. This is because individual assessments are based on a broader range of need-related factors, including the amount of informal care available. Thus scarce formal care can be better matched to the needs of individuals, and not simply provided as a substitute for ongoing informal care.
- If a means-test is also used, then public funds are not spent on people who are judged capable of self-funding.
- Choice can still be promoted through the provision of direct payments or individual budgets.

Possible shortcomings

However, Ikegami and Campbell (Ikegami and Campbell 2002) point to possible shortcomings of a typical tax-based system.

- The stigma of means-testing (if that is a feature of the system) may put some older people off applying for help.
- If the system is structured so that the service provision is a monopoly, there is little incentive to improve the quality of services provided.
- A seamless interface with informal or self-funded care can be hard to achieve.
- Differences in entitlement criteria and user charges between health care and social services can create a serious boundary problem.
- Devolution to local government can result in considerable regional differences within a country because of locally determined needs and financial eligibility criteria. Inconsistencies can also arise because when a needs assessment is predominantly based on an individual's circumstances, the system places much greater trust and responsibility on the assessor. However, there is no reason why a tax-based regime cannot be combined with national, more explicit eligibility criteria, as in Austria.

Social insurance programmes

In countries where care is funded through social insurance programmes (for example, Germany, Luxembourg, Netherlands). In this case, compulsory contributions are collected (usually, at the minimum, from employees and employers) and put into a designated (hypothecated) fund. A person then has an explicit entitlement based on nationally applied objective measures, which often include the number of ADL failures. Among the social insurance schemes currently in place, there is no means-testing and little or no consideration of the informal care that is available (in other words, these systems are 'carer blind'). Benefits from such a scheme could, in theory, be paid out in some way that varied with the wealth of the recipient. In some of these systems a care manager is available to help users to negotiate the provision of services. The level of benefits is set according to need, although a person's past contributions to the scheme may be relevant. Benefits can often be taken in cash or vouchers.

Potential advantages

The potential advantages are both administrative and practical.

- Administrative savings are made by removing the means test and simplifying the needs eligibility criteria. Everyone is generally clearer about which benefits are provided, and there should be no local variations so the system appears 'fairer'.
- The usual option of a cash payment encourages choice and competition.
- The system is easier to dovetail with private long-term care insurance, where eligibility is usually governed by an ADL-based algorithm.
- As the eligibility criteria are 'carer blind', this funding mechanism can also relieve the burden on informal carers (although, other things being equal, this increases the cost of the system).
- The eligibility criteria should be designed carefully to cover the disabilities of those with dementia.
- Some safety net provision can be put in place for older people who, for whatever reason, do not qualify under the social insurance scheme.

Potential shortcomings.

Explicit benefits can result in the inefficient provision of services precisely because the eligibility criteria are inflexible and an individual's particular circumstances are not taken into account. Two people with equal ADL limitations may have very different care needs, but they will qualify for the same state support.

There are also potential deadweight losses in that state funds go to people who would otherwise make private provision for the same services.

In addition, there is no in-built expenditure control 'affordability' mechanism if the costs to the public purse start to exceed resources. Explicit entitlements are very hard to strip back and several recently introduced social insurance schemes have proved more costly than anticipated.

Review of systems in other countries

A recent Organisation for Economic Co-operation and Development (OECD) study reviewed the different systems in operation in various countries (OECD 2005). The first five cases below (drawing heavily on the OECD's work) illustrate schemes that offer universal coverage with no means testing. Each raises funds from across the broad population including retired people, as well as employees and employers. But the methods of assessing needs vary in style and in the way decisions are made.

Austria

A universal system of long-term care allowances was introduced in 1993, funded by general taxation. All benefits are given in cash. Assessment is via a seven-point scale by type of care and number of care hours needed, with a medical report provided to the social insurance authorities. Residency in Austria is normally a qualification requirement. Income and asset tests are still applied in the case of intensive care needs where the care allowance does not cover all expenditure. In this instance, social assistance can provide means-tested extra funding.

Germany

A new scheme of long-term care insurance was introduced in 1995. This includes a compulsory public scheme covering 70 million people, and a private insurance scheme covering around 8.5 million people. A minimum of five years' contributions is necessary to qualify under the public scheme, but subsequently benefits are independent of total contributions. All private schemes must provide at least the same benefits as the public scheme. Civil servants are not covered by the public scheme and individuals with income over a certain threshold can opt out of the public scheme, but both these categories of people must enroll in a private insurance scheme.

Contributions to the public scheme are levied on the whole population, including retired people, and are set at 1.7 per cent of gross earnings (up to certain ceilings). Employers and employees usually each pay half the premium. One national public holiday was cancelled to compensate employers for the cost of the scheme. The private insurers operate under federal regulations and charge age-related premiums. Under both the public and private schemes, benefits for institutional care do not cover 'hotel' costs, and there are three defined care levels based on the number of times per day and the hours of care needed. The public scheme does not pay out unlimited cover, and private money can be used to 'top up'. Anyone receiving domiciliary care can opt for a cash payment, which in the public scheme is worth around half the cost of services in kind. In 2001 a cash-only option was taken up by around 73 per cent of users. For people dependent on income support, the local authority chooses between paying the social insurance contributions on behalf of the individuals concerned or taking the risk of having to pay for their care in the future (Karlsson *et al* 2004).

The financial costs of the German insurance scheme have created some challenges. In order to limit state expenditure, the level of benefits has been kept constant despite increases in the price of services, and there is some indication that the entitlements under the social insurance system are insufficient to cover reasonable care costs (Comas-Herrera *et al* 2003). Growth in expenditure has nevertheless outstripped revenues. Since 2005, one amendment has been to increase the contribution rates for employees without children from 0.85 per cent (half of the 1.7 per cent) to 1.15 per cent (up to an income ceiling). There is continuing debate over the sustainability of the system, and whether further amendments are necessary. In the early years, the new social insurance system greatly reduced the proportion of older people in institutional care needing social assistance payments. However, this trend has now been reversed. Interestingly, the market for voluntary private long-term care insurance has grown under the new system, with around 500,000 policies taken out to 'top up' the cover provided by the public insurance scheme.

Luxembourg

In 1999, the social insurance system was extended to cover long-term care, funded 45 per cent from general taxation, approximately 35 per cent (in 2001) from individual contributions from salary or pension(based on 1 per cent) , and the remaining 20 per cent from a special tax on electricity bills. Assessment is on a sliding scale based on hours of care needed with ADLs (above a threshold level). A multi-disciplinary team run by government medical staff uses medical and social reports to decide eligibility. To qualify under the insurance scheme, the expectation must be that the social care will be needed

for a minimum of six months. Payment levels for both residential and domiciliary care are based on the number of care hours needed and fixed amounts per hour. A cash option is available. Private funds are required to cover additional costs, which can be high for residential care, with means-tested help from social assistance for those who need financial help (about one in ten of people receiving care). Since the system was adopted, there has been a shift from residential to domiciliary care. In its first four years, the scheme operated with a financial surplus.

Japan

In 2000, a system of public long-term care insurance was adopted covering those aged 40 and over, funded 50 per cent from general taxation (split between central, regional and municipal finances), 32 per cent from employees aged 40 to 64 (approximately 1 per cent of income up to a ceiling) and 18 per cent by contributions from pensioners. The rate of contribution is adjusted to cover costs, and contributions increase with income up to a maximum. Contributions from the poorest people are subsidised by the state. Benefits are paid according to a national scale and are received as services from approved providers (there is no cash alternative). The user pays a co-payment equivalent to 10 per cent of the cost of the services (but is means-tested). Assessment is on a 6-point scale related to time needed with ADLs and 'instrumental activities of daily living' (IADLs), and also involves a case conference of health and welfare professionals. As in other countries, the balance of care has shifted from residential units to domiciliary care.

There is no option to take a cash payment rather than services, because one of the goals of the scheme was to reduce the burden on informal family carers. Cash alternatives were seen as likely to encourage family members to continue to provide care.

There is mounting evidence that the Japanese social insurance model is struggling to cope with the expenditure pressures imposed by its original care settlements. As a result, it is in the process of tightening its eligibility criteria for publicly supported care. Wary of the demographic pressures that lie ahead, the government is also considering various ways to make the system more financially sustainable, given projections that big increases in future contributions will be necessary under the existing scheme.

Netherlands

A comprehensive public insurance scheme covers 'catastrophic' or 'exceptional' risks including a broad range of long-term care services across a range of settings (it also covers acute health care needs as well as long-term care). Since April 2003 the benefits have included an entitlement to a personal budget in cash to spend on care. The funding comes 88 per cent from contributions from working-aged people, and 11 per cent from contributions from older people (in each case, 13.25 per cent of taxable income, with an annual maximum of €4,004 from 2003, including the health cover element).

The use of means-testing varies greatly across the countries which have a social care system funded from general taxation. In several cases, these regimes have been reformed in recent years because of the rising costs of care for the elderly. The following summary also draws heavily on the OECD study (OECD 2005).

Sweden

Sweden is one of the highest OECD spenders on long-term care for the elderly as a proportion of gross domestic product (GDP) (2000 figures). The system is funded from local and regional tax revenues with minimal user fees. In order to contain costs, home care is now targeted more heavily on those with greatest needs. Only about 4 per cent of the costs are financed by fees or rates, according to the Swedish Ministry of Health and Social Affairs (Swedish Government, Ministry of Health and Social Affairs 2005). Within the framework of the rules, each municipality decides its own system of charging and the fee payable by the individual. This is based on the number of hours used and on taxable income, but only up to a legal maximum. In July 2002, a national cap on out-of-pocket payments was introduced of 1,516 Swedish kroner (£106) per *month* for personal services and 1,579 Swedish kroner (£111) per *month* for accommodation costs (Karlsson *et al* 2004).

Australia

Reforms implemented in 1997 put more responsibility on users with higher incomes and assets to contribute to the costs of long-term care. Residential care homes may levy a number of fees and charges, although a resident may not be responsible for paying for all of them. The 'basic daily care fee', based on the state pension, contributes to living expenses like meals, laundry, heating/cooling, and nursing and personal care. Residents (other than respite residents) may also be asked to pay an 'income-tested care fee', depending on their income and level of care.

In addition, care home residents are asked to contribute towards the cost of their accommodation by paying an 'accommodation bond' (if in low-level care) or 'accommodation charge' (if in high-level care). A resident can only be asked to pay a bond or charge if their assets exceed an amount set by the Australian government. Accommodation bonds are in effect an interest free loan to the care home and by law must be used by the home to improve building standards and the quality and range of care services provided. The care home is allowed to deduct monthly amounts, called retention amounts, to use toward maintaining and improving the accommodation, for example, by purchasing new furnishings, improving gardens, and renovating buildings. The Australian government sets a maximum amount that the care home can retain, and retention amounts can only be deducted for a period of up to five years. The care home also keeps the interest received on the bond while the user is a resident. The bond balance is refunded when residential care is no longer required.

Similarly, the accommodation charge is used by care homes to maintain and improve the accommodation. The amount is agreed with the care home, but the Australian government sets a maximum. This is calculated on a sliding scale, depending on the value of the user's assets. In addition, no one can be asked to pay an accommodation charge that would leave them with less than a specified level of assets. Before 1 July 2004, the accommodation charge could only be levied for five years, but since that date it has been open-ended. A resident may be eligible for state assistance with the cost of their accommodation, depending on the result of an assets assessment. The value of the home is included in the means-testing, but the Australian government regulates the maximum charges (Australian Government, Department of Health and Ageing, 2005).

For older people receiving a care package in the community, maximum charges are also set according to income and assets. Anyone on the full state pension (which is means-tested

in Australia) cannot be asked to pay more than 17.5 per cent of that pension. Somebody with a higher income may be asked to pay more, with a maximum set at 50 per cent of that higher income. The value of the house is discounted in the means test for domiciliary care. A recent inquiry into funding (Hogan 2004) considered this to be a disincentive for older people to move from unsuitable, large homes into accommodation more appropriate for receiving care at home. It suggested ways in which such downshifting might be encouraged. This included 'exempting the value of the [proceeds] and any subsequent purchase of appropriate aged care housing from taxation or assessed valuations for residential aged care participation until the resident no longer requires care'.

New Zealand

District health boards assumed responsibility for long-term care in 2003 under a reorganisation. Long-term care is funded from general taxation, with block grants from central government. The means-testing system is being adjusted in stages so that asset tests for residential care subsidies are phased out, leaving only income tests. This will make the system more generous for users.

Norway

Long-term care is largely financed from general taxation, with user fees. Users of residential homes contribute approximately 80 per cent of their public pension, up to a limit. Home help is also subject to a user payment, which the local council has the freedom to drop in certain cases.

Denmark

A country with a tradition of decentralisation, Denmark has high rates of both institutional and home care, although it strongly promotes home care over residential care (Korczyk 2004). Long-term care is funded from municipal taxation, which covers both home nursing and personal care services. The country's philosophy is that there should be less reliance on informal care than in many other countries. Anyone over 75 receives two home visits a year to identify potential social, physical and psychological risks, health promotion advice and any necessary referrals. Denmark is also unusual in providing some domestic services (i.e. housework) under its long-term care packages, although this is not true in all municipalities (Glendinning *et al* 2004).

United States of America

If an older person cannot afford to fund long-term care, the costs are met through Medicaid after a means-test. Medicaid is jointly funded by the federal and state governments through general taxation. The means-tests for Medicaid are strict. An individual must either have very low income (below 75 per cent of the poverty level) and assets (below $2,000 per person) or be 'medically needy'. In the latter case, all of the user's income (apart from a small allowance) must be contributed to the cost of care, and assets must be spent down to below the asset limit (not including housing assets) (Gale *et al* 2004).

Medicare, the other public funding mechanism, is not designed to cover long-term care. It compensates nursing home costs only if the insured has been treated in a hospital for at least three days, and then only reimburses costs for doctors' and nurses' services. Home

care is provided only if the client needs skilled nursing care and is homebound. However, for clients meeting the requirements, personal care services may be provided as well. Most importantly, Medicare benefits have a time limit. Hospital stays are only covered for the first 60 days, and nursing home costs are only covered for the first 20 days; after that, a certain fraction of the costs are covered for another 80 days. Thereafter, the insured cannot get any benefits from Medicare. (Karlsson *et al* 2004).

Overall, total sources of payments for long-term care costs are broadly split between Medicaid 45 per cent; Medicare 14 per cent; out-of-pocket 23 per cent; private insurance 10 per cent; other 7 per cent. Out-of-pocket spending as a percentage of all spending on nursing home and home health care is over twice as large as that for hospitals and professional services (Gale *et al* 2004). Only about 10 per cent of the elderly have private long-term care insurance (LTCI), and it is usually purchased after the age of 55 (the average age of buyers in 2000 was 67) (Brown and Finkelstein 2004b). The take-up of insurance correlates with income levels. According to the OECD, 15 per cent of those with annual incomes above $20,000 now have long-term care insurance. From late 2002, federal government employees and relations (about 20 million people in total) have been able to buy LTCI at discounted group rates from approved insurers. About 3,500 firms also offer LTCI to employees.

Researchers at Cass Business School (Karlsson *et al* 2004) looked at the financial impact of importing the Swedish, Japanese and German systems into the UK (note, not England). In each case these alternative funding models implied increased public costs in the UK. The report concluded that switching to any of these three regimes would mean that UK taxes would need to increase above any implied increase in UK tax and contribution rates based on current UK practice. These researchers found a switch by the UK to a Swedish-style system would benefit females, relatively old people and low-income earners, whereas young people would be clear 'losers' from such a reform. This is due to the fact that a comprehensive tax-based system benefits people with low incomes and people with higher needs (women and old people). A switch to a Japanese-style system would, on the other hand, benefit young people, since they play a minor role in the financing of the social insurance system. A switch to the German system would benefit only young males, whereas all other groups would fare worse.

Options for state-organised funding of social care

Chapter 12 (Section 3) of the Review outlined a range of ways to structure the state funding of social care for older people, including the provision of free personal care. This section provides some additional information on the options covered.

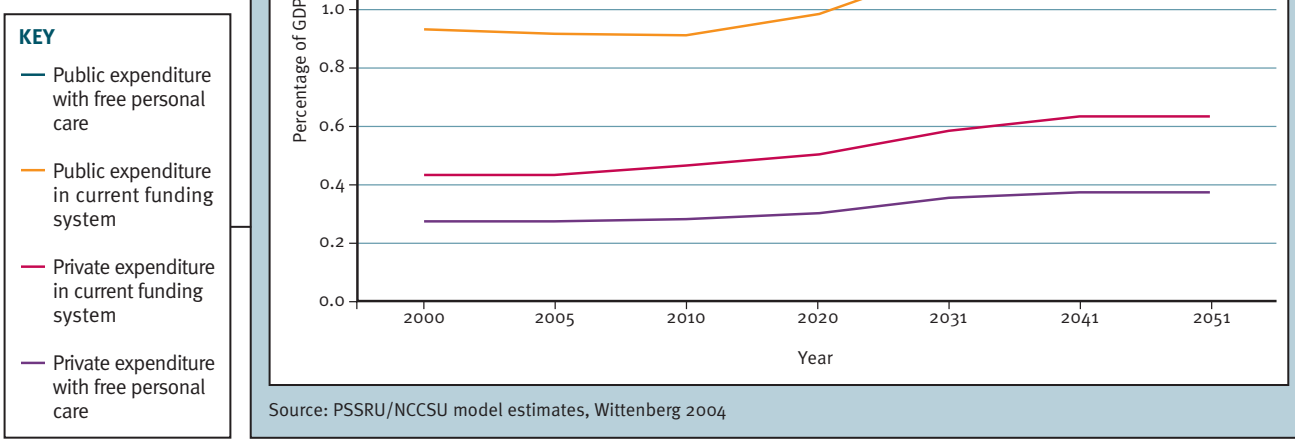
Free personal care

An independent projection of the costs of free personal care and free nursing care (Wittenberg *et al* 2004) in the UK found that (under the central base case assumptions) the policy would have increased public expenditure in 2000 from approximately £8.8 billion to approximately £10.3 billion under a 'base case' scenario. Private expenditure would have fallen from around 32 per cent to around 20 per cent of all expenditure on long-term care.

Looking ahead, public expenditure – expressed as a percentage of GDP with free personal and nursing care – would have risen from 1.09 per cent of GDP in 2000 (compared with 0.93 per cent under the current funding system), to 1.45 per cent of GDP in 2051 with free personal care (compared with 1.2 per cent in 2051 under the current system).

The projected impact of free personal care on public and private expenditure on long-term care is illustrated in Figure 1. Two important differences ought to be noted when comparing

1 **PUBLIC AND PRIVATE EXPENDITURE ON LONG-TERM CARE AS A PERCENTAGE OF GDP UNDER THE CURRENT FUNDING SYSTEM AND UNDER FREE PERSONAL CARE, UNITED KINGDOM, 2000 TO 2051**



Source: PSSRU/NCCSU model estimates, Wittenberg 2004

these estimates of the cost of a free personal care system and those derived by the Review in Chapter 13. First, these projections assume that a shift to free personal care has no effect on the number of older people in receipt of services, in other words that there is no demand effect. Secondly, they assume current care package levels, rather than the more expensive benchmark care packages derived in Chapter 10 of the Review.

If the numbers of people with dependency do not rise as fast as the base case assumes (rising instead according to the model's low base case) , then the estimated percentage of GDP spent under a policy of free personal care in 2051 would be 1.07 per cent, that is, not much higher than it is today. However, if dependency rates and unit costs were higher than the base case (the model's high base case), it would increase to 2.7 per cent of GDP. The funnel of doubt is therefore considerable.

In practice, the provision of free personal care would be expected (to some extent) to increase the demand for care, and this demand effect is not included in the above figures. Any forecast suffers from the problem of not knowing what the demand effects will be. The Wittenberg projections suggested that, under a scenario in which there was a 12 per cent increase in demand for domiciliary services, public expenditure on long-term care would increase to 1.48 per cent of GDP in 2051; while a 25 per cent increase in demand for care would push this up to 1.51 per cent. However, these increases were fairly modest when compared to the central base case scenario.

The model also tested the question of who would benefit most from free personal care. Using figures for people aged 85 and over (Hancock *et al* 2003), three income bands were specified for people in care homes in 2000: under £4,540, £4,450 to £12,870, and over £12,870 for older people in residential care; and under £4,490, £4,490 to £12,040, and over £12,040 for older people in nursing homes. The model confirmed that the introduction of free personal care would have no effect on the lowest income group as the current funding arrangement already meets almost all the costs of those on the lowest income. In the middle income group, there would be small rises in the share of fees met from public sources, but the largest increases would be for the highest income group. 'As a result of the introduction of free personal care, in the base year, the share of fees met by residents and their families in the highest income group would reduce from 89 per cent to 48 per cent. For nursing home care, the reduction would be from 69 per cent to 34 per cent,' the study found. (In practice, this relatively wealthier (but far from rich) cohort might well have been paying more tax or social insurance to fund the system of free personal care.)

Varying the current means-testing system

The problem with means-testing is that it may 'inappropriately' distort a person's behaviour. It can create a disincentive to save, or encourage a person to give assets away in order to avoid future liabilities. Most importantly, if a means-testing system is misjudged in terms of the income and assets thresholds, the cost of long-term care can fall very harshly on families whose care needs are great, and who are by no means wealthy but fall outside the eligibility range. Thus, it can create a high level of unmet need. This section expands on Chapter 12 of the Review.

As described in the Review's Chapter 6, the practical application of the means-tested model in England involves a complex set of rules to determine who is eligible and who is

not. In considering alternative funding arrangements, one option is to re-configure these rules, but to keep the essential character of means-testing. For instance, a quantitative study (Hancock 2000) of the impact of varying the means testing rules showed that 'disregarding more income in the means tests would be well targeted on the poorest and cost less than disregarding more capital. Substantial increases in the capital limits, particularly the lower limit, would be needed to reduce noticeably the amounts older people are required to pay towards residential care. This is because, whatever their capital, people have to put nearly all their income towards the cost of residential care'.

The study also found that in 15 years' time (2015), higher rates of owner-occupation would mean that a bigger proportion of older people would have to meet the full costs of residential care (60 per cent compared with 50 per cent). Therefore any relaxation of the capital rules for residential care would cost the state more in 15 years' time than it would have cost in 2000. The cost of disregarding more income would also be higher in 15 years, but much less so than for any easing of the capital rules.

The existing means-tested system assesses both income and assets, so there are many possible permutations for introducing changes.

- Raise the higher assets threshold (£20,500 in 2005), and also allow people to top up their state-funded residential care packages if they wish. Even just doubling the upper threshold would remove a number of people from paying full charges for community-based care (as the value of the house is not included in the assessment), but all those people would have to undergo an initial financial assessment in order to be exempted. If the new higher threshold was set above the value of a low-cost property, then this would greatly increase the number of people who would have to be financially assessed in detail for care home place state support (because the value of a property would no longer on its own rule out state-funding). Offsetting this, such individuals would be paying more tariff income, which would be calculated on the majority of the person's assets up to the new higher threshold.
- Raise the higher and lower assets thresholds. Many more people would then qualify for free community-based care. But everyone below the lower threshold and entering a care home (with state funding) would still lose all their income, apart from the £18.80 (2005) personal allowance. More people would have to be financially assessed.
- Scrap the 'window' between the higher and lower assets thresholds (currently a spread of just £8,000). This has the merit of removing the complex tariff income calculations. Its acceptability would depend on the level at which the sudden 'cliff-face' cut-off was set. At the moment, the difference in weekly contributions between someone with assets at the higher threshold (£20,500, 2005) and someone with assets at the lower threshold (£12,500, 2005) is £32 a week.
- Widen the 'window' between the higher and lower assets thresholds. This would mean more tariff income calculations, but a longer, gentler 'slope' between no asset-related charges and no state funding (it is important to remember that income is also assessed). However, in order to be accurately implemented, the tariff income calculation needs to be re-done regularly to take account of 'spend-down' of assets. Thus the administrative burden of a wide 'window' might not be cost-effective.
- In any scheme where a 'tariff' income is charged on savings, alterations can be made to the tariff rate – currently £1 for every £250 within the assets thresholds. Age Concern (Thompson and Mathew 2004) recommended a rate of £1 per £1,000 (with no upper limit above which there would be no public funding) for those receiving domiciliary care

in recognition that older people living at home may need to use their capital for other expenditure.

- The very low personal expense allowance of £18.80 a week (2005) for someone receiving state-funded residential home care could be increased. Similarly, the net residual minimum income for someone receiving domiciliary care could be increased above the current level of 125 per cent of the appropriate Pension Credit rate.
- Under the current system, someone who has saved in an occupational or personal pension may end up no better off than a person who did not do so. This is because the extra income will be counted towards the social care charges. It might encourage people to save for a pension if a certain amount or proportion of occupational or personal pension income was exempted from the social care means-testing regime.

The treatment of an older person's property assets within the means-testing system is an emotive issue. Older people often resent having to sell their home in order to fund care home fees, but it would be difficult to argue that property assets should be treated any differently from other assets when someone has moved into a care home and no partner (or other qualifying individual) remains living in the home. Under the current rules, the value of a property is ignored for the first 12 weeks when an older person is means-tested. Given the shortage of property, it would seem to be against the wider interest for homes to be left empty in the medium or long term. However, if more emphasis were put on care with rehabilitation, it might be preferable for the 12-week period of exemption to be longer, or more flexible, so that more time could be given to consideration of whether a person might eventually be able to return home.

Under the existing means-testing rules, there is in fact a perverse incentive for an older person with substantial financial assets to trade up into a *more expensive* home if it is likely that they will want domiciliary care. Similarly, there is a disincentive for a person with housing assets to downsize into a smaller, more appropriate house, even if this would be a sensible thing to do, because the capital released could remove the person's eligibility for state-funded domiciliary care. The Australian study mentioned earlier (Hogan 2004) suggested ways in which the proceeds of downshifting might be shielded from tax. By the same argument, there could be some form of exemption from the social care means-testing assessment of the proceeds of downshifting. A wider social benefit would thereby be encouraged in terms of a more efficient use of property.

Co-payments

In the current means-tested system in England, individuals potentially pay a charge that is based on their income, assets and the cost of the care package. Some people pay nothing; some potentially pay the full cost. Instead, a co-payment could be made that is either a fixed proportion or a fixed absolute amount, applied universally. This co-payment would have to be means-tested to avoid it being regressive; alternatively, there could be some cut-off so that co-payments only applied, for instance, to users on a full basic state pension, regardless of total income level, or were not charged to anyone in receipt of a particular state benefit such as Pension Credit.

In Japan's social insurance system, there is no means-testing for services but a flat-rate 10 per cent co-payment is charged on the cost of the care package, with a lower rate for those with less income. The system was introduced in 2000, and one study (Campbell and

Ikegami 2003) found that the programme in its first two years had operated 'within its budget and without any major problems'. At that point the program was costing about $40 billion, and was expected to rise to about $70 billion annually by 2010 as applications for services went up. There were about 2.2 million recipients, equivalent to 10 per cent of the population aged 65 and over. Campbell and Ikegami found that the co-payment had led to users paying close attention to relative prices, in that personal care workers were less popular than 'housekeeping' home help, which had a much lower hourly fee. (No cash direct payment is offered in the Japanese system.) As mentioned earlier, the Japanese social insurance model is struggling to cope with the expenditure pressures imposed by its original care settlements and is tightening its eligibility criteria for publicly supported care.

Adjusting the amount of the co-payment could thus provide a way to contain demand to a lesser or greater degree. A co-payment system provides a direct test of how much an older person values a particular service, so long as the co-payment is affordable. The impact will depend on the elasticity of demand, and the relative crowding in and crowding out effects. Co-payments also provide a revenue stream for the funding of social care, and depending on how they are structured, can be used to make the system more progressive. In practice, however, the system can be subverted if the co-payment is implemented via a reduction in the entitled services, rather than actual payment of charges (Glendinning *et al* 2004). This would mean that the user would receive less support then they had been assessed as needing, unless they then 'topped up' with privately purchased services. Of even greater concern would be a situation where individuals turned down the care altogether because they felt the co-payment was too high. Depending on the means-test rules, this is likely to be more likely for the poorer and more vulnerable. It is therefore possible that a co-payment system would lead to greater dependency later on among those for whom the co-payment was a significant disincentive to seeking social care.

One administration that has recently adopted a social insurance system with flat-rate benefits and a co-payment is Guernsey, in the Channel Islands. The island's Long-term Care Benefit was introduced in 2003. It is a weekly benefit that is paid towards the cost of the fees of a private residential or private nursing home. It does not yet cover domiciliary care. It is funded by a 1.4 per cent tax on earnings between £93 and £660 a week (2005 figures) (raising the total employee insurance contribution to 6 per cent, somewhat lower than in England). The benefit is paid out at £301 a week for a residential home and £560 for a nursing home. In both cases a co-payment of £133 must be paid from private funds. (If an older person cannot afford the co-payment, Supplementary Benefit may help, in which case the value of the former home is ignored in the financial assessment.) In order to claim the benefit, a person needs to have lived in Guernsey or Alderney for a continuous period of 5 years and for at least 12 months immediately prior to claiming the benefit.

Attendance Allowance at £72.25 (2005 figure) is not paid to someone receiving the benefit. (In Guernsey, Attendance Allowance is also means-tested and not paid to anyone with an annual income over £66,000.) One of the explicit principles of the scheme when it was introduced was that people should not have to sell their homes before receiving help with care home fees.

Until the system is extended to cover care in the home, it creates an incentive to move into residential care. It also encourages the former home to be kept on, even if empty. The funding mechanism appears to be fairly regressive, given the top earnings threshold for

contributions, but this would not have to be the case in such a system. As a small island with strict residency laws, it is easier for Guernsey to implement the strict residency requirements of the benefit, something which might be more difficult in England. All that said, Guernsey provides an example of a system that has been subject to recent, significant change.

Long-term Care Insurance

Chapter 12 (Section 4) of the Review summarised the types of Long-term Care Insurance (LTCI) that have been available commercially in recent years and looked at the reasons for the sharp decline in the market. This section presents a fuller overview of the sector.

There are various insurance-based products that provide long-term care benefits. For most plans, benefits can be claimed if the policyholder can no longer perform a specified number of ADLs or are cognitively impaired. The recipient is given a choice about the type of care that is delivered, and whether to receive this care in a residential unit or at home. Premiums are generally set according to the individual's circumstances (so-called 'experience rating'). Private insurance is entirely voluntary; there are no collective enrolment aspects to this arrangement. Risk pooling occurs as a result of other members paying into the scheme and adding to a funded insurance pot.

At first glance, there ought to be a market for LTCI. A fairly predictable proportion of the population will need LTCI, and for a minority the costs will be catastrophic. It is therefore attractive to limit financial exposure for the individual by pooling the risk. The market for LTCI products, however, remains very small. Sales of policies failed to meet expectations to such an extent that most of the providers of pre-paid insurance have withdrawn from the market. People are generally reluctant to think that they may need social care in the future, and many individuals with inadequate pension savings would in any case arguably be better advised to boost those before opting for LTCI. The historically small market for LTCI is probably exacerbated by a general lack of knowledge about the limited provision of state-funded care, plus uncertainty about what that future provision might include and how services may evolve.

Pre-paid LTCI

With pre-paid LTCI, regular or lump sum premiums are paid by the policyholder in the years before long-term care is needed. If the person should need long-term care, the policy pays out a set annual cover amount (which can be index-linked) throughout the time the care is needed, however long that may be. Thus the pay-out is determined by an amount that was fixed when the policy started, rather than by the actual cost of care. The policyholder must meet any difference between the insurance cover and the actual cost of the long-term care.

The policyholder's state of health is taken into account when setting the premiums, but the insurer usually has the right to review the premiums at a later date. The policyholder can choose the type of care received, and this can change as the level of dependency progresses. There is generally no refund of premiums in the event of cancellation and no refund on death.

Sales of both the regular premium and the single premium insurance policies have shown a big decline since their peak in 1996, according to data from the Association of British Insurers (ABI). At the end of 2004, there were 18,825 regular premium pre-funded LTCI policies in force, and 10,517 single premium policies in force. In both cases, 60 per cent were held by women, and 40 per cent by men. Only 17 per cent of regular premium and 5 per cent of single premium policies were held by people under the age of 60.

During 2003, the latest individual year for which figures are public, just 1,592 regular premium and 892 single premium pre-funded LTCI policies were sold, compared with 3,575 and 4,505 respectively in 1996. Total premium income received by insurers for all regular premium policies in force amounted to £20.6 million in 2004. Single premium policies brought in £14.2 million in 2003 (the latest figure), equating to an average cost of just under £16,000. The value of claims paid out during 2004 was £3.7 million and £5.2 million respectively.

Following the withdrawal from the pre-funded LTCI market of most of the providers, only one UK company currently offers a pre-funded product. Partnership Assurance (formerly PAFs) launched 'Care Prepared' in mid-2005, with the choice of regular or one-off premiums and various periods of deferment before the benefit would start (the longer the deferment period, the lower the premiums). Tables 1 and 2 (below) give sample premium figures for standard cover for a healthy woman and man aged 50 who want a future monthly benefit payment of £1,000. The premiums increase with the age of the person taking out the policy. The standard cover starts paying the regular monthly benefit only after 3 ADL failures, or when help is needed because of mental impairment. It can be seen that this type of insurance is out of the price range of many people, especially women, for whom the premiums are much higher. Because of the impact of inflation on the real value of £1,000 over many years, anyone taking out pre-paid insurance would probably be advised to opt for the 3 per cent escalator product, which inevitably makes the product much more expensive. (As with all these types of products, because of the shortage of market data, the monthly premiums are also only guaranteed not to rise for five years.)

Investment-based bonds

This type of plan was designed so that if long-term care were not needed, there would be some residual financial benefits available to the policyholder and/or the policyholder's heirs. Depending on the structure of the plan, some further financial benefits might also be available even if long-term care were needed. It should be said at the outset that this type of product was a casualty of the sharp stock market declines following the dot com boom. No UK company is now selling long-term care investment bond products.

An investment bond is purchased with a lump sum. The premium needed to pay for the pre-paid LTCI policy is then withdrawn by the company each month from the value of the investment bond. In the meantime, the investment element continues to be fully invested. There is both investment growth potential and risk with these plans. For example, it is possible for the plan to increase and decrease in value. If it decreases significantly then the benefit amount may have to be reduced or a top-up paid.

If care is never needed, the value of the bond is returned to the policyholder's estate. This residual value will be the investment plus any growth, minus the insurance premiums.

TABLE 1: SAMPLE PREMIUM FIGURES FOR LONG-TERM CARE INSURANCE FOR 50-YEAR-OLD WOMAN SEEKING MONTHLY BENEFIT OF £1,000

		3-month deferment	6-month deferment	12-month deferment	24-month deferment
Monthly premiums	**0% escalator**	£72.85	£68.77	£61.85	£50.99
	3% escalator	£185.37	£174.00	£154.62	£123.91
Single premium	**0% escalator**	£13,431.00	£12,671.00	£11,381.00	£9,353.00
	3% escalator	£34,448.00	£32,327.00	£28,711.00	£22,984.00

Source: Partnership Assurance 2005

TABLE 2: SAMPLE PREMIUM FIGURES FOR LONG-TERM CARE INSURANCE FOR 50-YEAR-OLD MAN SEEKING MONTHLY BENEFIT OF £1,000

		3-month deferment	6-month deferment	12-month deferment	24-month deferment
Monthly premiums	**0% escalator**	£49.42	£45.89	£40.37	£32.63
	3% escalator	£111.25	£102.13	£87.77	£67.41
Single premium	**0% escalator**	£8,644.00	£8,016.00	£7,035.00	£5,657.00
	3% escalator	£19,685.00	£18,061.00	£15,502.00	£11,872.00

Source: Partnership Assurance 2005

Under some schemes, if a claim is made on the insurance policy, any remaining balance of the residual value of the investment bond can be returned to the policyholder at any subsequent time.

There are several ways to structure a plan; the main differences relate to the payment of claims. Some plans will guarantee to protect the initial investment, and the insurance element then pays the benefit from the outset. Others will use the remaining fund value to pay the benefit amount before the insurance company takes over payment. With the former plan, the policyholder keeps the investment after a claim, and it can be spent or accrued to the value of the estate. With the second type of plan, the policyholder still has the peace of mind that care costs will be met (after the investment element is depleted, the insurance cover will continue to pay out for as long as care is needed). But there is no investment value after a claim. Consequently, the second type of plan is cheaper. The investment bond can be cashed in at any time before a claim, but this can void the LTCI.

At the end of 2004, Association of British Insurers (ABI) figures show there were 11,237 care bonds in force. Some 68 per cent were held by women and 32 per cent by men, and 24 per cent were held by people under the age of 60. During 2004, just 51 care bonds were

sold, down from 1,573 in 2000. Total new premium income in 2003 was £3.2 million, and the value of claims paid was £1.24 million.

Several of these products have failed to live up to their customers' expectations because of the insurers' right to review premiums after several years. Scottish Amicable's long-term care bond was withdrawn in August 2003 and several thousand policyholders were told that they would have to make extra contributions or accept lower cover because the investment bond was not producing adequate returns to meet the benefits. (Scottish Amicable is now owned by Prudential.) Axa PPP has asked its long-term care customers to top up plans (sold under the PPP brand) to retain full cover (Levene 2005). Axa PPP said the big premium increases were due to higher than estimated claims. 'People are living longer so they are more likely to make a claim. And 35 per cent of our claims involve dementia, which can mean paying out for many years as the policyholder remains physically fit. So we have had to increase premiums, or reduce benefits or cut future inflation proofing. This far, about 20 per cent have opted to pay more.'

Immediate needs annuities

These are annuities purchased with a lump sum to pay for immediate care. If an older person is in poor health and already needs care, or is about to go into a nursing home, it is possible to pay a single premium to buy an annuity policy which will begin paying a fixed amount towards care immediately. These policies guarantee future payments, at the pre-fixed levels, towards the cost of residential home fees or domiciliary care for as long as necessary. In practice, many purchasers have used the proceeds of a house sale to fund the immediate care annuity, so it is less common for this type of funding instrument to be used to pay for domiciliary care. The benefits can be index-linked, but this pushes up the cost. The policyholder must pay any difference between the pre-fixed policy benefit payment and the actual cost of the long-term care.

There is no income tax payable on the annuity benefits, provided they are paid direct to a formal care provider (that is, not a friend or relative). These annuities can be attractive because for the majority of people paying for care, the biggest concern is the unknown period of time for which those costs will be payable. The annuity 'caps' the cost of care at a set initial lump sum amount.

If the individual dies, there is no return of the capital invested. However, some products can include an extra insurance element that provides for some assured minimum return if death takes place within a certain time. There are two common forms of such insurance: Guarantee Period, whereby the income is payable throughout an agreed period (usually a maximum of three years) even if death is sooner; and Capital Protection, which pays out a chosen percentage of the capital invested, less any income already paid out. The cost of such insurance can be expensive, and significantly increases with the age and ill-health of the policyholder.

Only four UK providers currently offer immediate needs annuities, and the cost of the product varies widely for exactly the same benefit levels. One actual example is given in Table 3 opposite for the annuity purchase price for a woman aged 92 who wanted an annual income of £18,000. The huge spread of quotes clearly demonstrates that anyone interested in this type of product should shop around. Given the age of the woman, the

TABLE 3: SAMPLE QUOTES FOR ANNUITY FOR 92-YEAR-OLD WOMAN SEEKING ANNUAL INCOME OF £18,000

	No RPI[1] link		Escalating at RPI[1] + 2%	
	No capital protection	50% capital protection	No capital protection	50% capital protection
Provider A	£49,289	£57,028	£52,582	£61,504
Provider B	£75,224	£82,239	£90,434	£100,506
Provider C	£62,061	£70,079	£67,381[2]	£77,030[2]
Provider D	£54,972	n/a	£65,571	n/a

Source: The Care Funding Bureau (unpublished)
[1] RPI = Retail Prices Index
[2] Escalates at 5%.

high quotes look particularly expensive. (The provider companies have not been identified.)

Immediate care annuities are the only part of the LTCI market that are showing any growth, albeit from a very low base. There has been a steady increase in sales since these products were introduced. According to the ABI, at the end of 2004 there were 4,342 immediate needs annuities in force. Some 82 per cent were held by women, and 18 per cent by men, and 88 per cent of the policies were held by people over the age of 80. During 2004, 1,730 LTC annuities were sold, for a total premium cost of £111.2 million. This would mean an average cost of around £64,000 for an annuity. The value of claims paid out during 2003 was around £43 million.

What future for LTCI?

LTCI appears, at present, to be in decline, and most industry players see immediate care annuities as being the only viable part of the industry for the time being. Price, uncertainty and complexity are usually cited as the reasons why pre-funded LTCI failed to take off. Another restraining factor was that the products did not come under regulation by the Financial Services Authority until October 2004. Regulation now means that all LTCI advisers (including existing advisers) will need to pass an appropriate exam to advise on, or sell, LTCI. There are new LTCI claims handling rules to increase consumer protection at the point of claim, when these policyholders are, by definition, particularly vulnerable. Even so, pre-funded LTCI schemes are likely to come a distant second to the need for better pension provision among most of the working population when planning for the future. The minority who can afford the current typical premiums are probably also in the best position to fund long-term care – if they ever need it – out of savings. Those who could most benefit from LTCI – the 'middle wealth' cohort – are much less likely to be able to pay for it.

In the end, most insurance providers dropped out of the pre-funded LTCI market because they were caught in a vicious circle whereby they could not sell enough policies to achieve

the economies of scale that would have allowed them to bring down the price to a level at which individuals would buy the products. Adverse selection may have played a role, in that it was those who had reason to believe they might need long-term care who took out the policies. Re-insurers generally lost money, but customers were still left feeling that the premiums were very high. In addition, some of the investment-backed products sold were based on unrealistic assumptions about market growth and when they underperformed it soured the overall market.

The central problem for the providers was the lack of adequate data on which to base estimates of future claims. Many of the insurance companies were caught out after they sold policies in the mid-1990s because most of their customers were from the cohort whose life expectancy was increasing fastest. Forecasts are needed for morbidity, the prevalence of various degenerative conditions, and the impact of any future treatments. For example, a new drug which extended the period of decline for someone with dementia would end up being very expensive for insurers, who are already most concerned about dementia-related claims.

In discussions, most industry representatives said they did not see a future for LTCI as a mainstream product unless it was part of a wider partnership package, or tax incentives were introduced to make it more attractive to consumers. On the latter point, two possibilities have been suggested by providers: i) premiums could be made tax deductible, and ii) the proceeds could be ignored in the means-test assessment. However, tax breaks for LTCI premiums would be controversial, because this might simply subsidise those who in practice can most easily afford to pay for social care.

Perhaps the underlying problem with pre-funded LTCI is that insurance tends to work best when relatively few people claim. But extended life expectancy and better health care mean that a sizeable proportion of the community may well need social care at some point before they die, so there are fewer non-claimants with whom to spread the risk.

Various ideas have been presented for how LTCI could be incorporated into other facets of providing for old age. St John (St John and Chan 2005) suggested that there could be a reduction of 5 per cent in the state pension for new retirees in exchange for long-term care insurance. Alternatively, or in addition, there could be a life annuity product that incorporated long term-care insurance paid for by cash, pensions savings and equity in one's own home (see below).

LTCI public-private partnership arrangements

There are various ways in which LTCI could play a part in a public-private partnership deal for the funding of care:

- Individuals could be liable (under the means-tested charging regime) for an initial fixed period of long-term care costs, with the guarantee that the state would then step in to pick up the bill. The private liability for long-term care costs would thus be capped. If that initial period was, say two years, then an individual could choose to take out LTCI to provide for care costs during that period. From the insurers' point of view, this would be a fairly easy risk to quantify because the insurance benefit would at the most be payable for two years. The self-funding consumer would have a choice of ways to fund the first two years: from savings; by earlier in life taking out a regular premium or single

premium pre-paid LTCI; or possibly by taking out an immediate needs annuity, although this would probably only be relevant if that initial period was somewhat longer than two years.

- A reverse version of the above could involve the state paying the costs for an initial fixed period of X years, with individuals assuming responsibility for the (means-tested) costs of care *after* that period. That residual period could be provided for through LTCI, either through a pre-paid scheme or an immediate needs annuity. This type of insurance would cover the 'catastrophic' minority cases where someone needed more than X years of social care, rather than the more predictable initial fixed period of social care. This open-ended cover is more typical of an insurance-covered risk. However, insurers would again suffer, at least initially, from the problem of lack of adequate data for pricing a pre-funded product for this purpose.
- Other formats would be possible. For instance, the state could fund the first year of care, the individual could then become liable for a set period, and then the state could take over again. Thus the user would avoid an early financial crisis, and would be protected against catastrophic long-term care costs, but the state would not be left funding everything.

The degree of risk-pooling through LTCI would vary with the structure of any partnership scheme. Extra public funds would be needed to cover the additional care funded by the state. There does not appear to be much scope for these types of partnership deals to save the state money, given that people who qualify for state funding do not have the money to purchase long-term care insurance. Nor do these partnership arrangements, on the face of it, appear to reduce the amount of means-testing that would be necessary. There are also a number of practical issues which would need to be addressed.

- The state and the LTCI industry would need to reach an agreement on the national eligibility criteria to determine the starting point of any long-term care. As mentioned earlier, insurance companies (when they offer such policies) need objective, standardised criteria that do not change over time, and have tended to rely on an algorithmic approach to eligibility based on an older person failing a pre-agreed number of ADLs. In contrast, local authorities use an individual-oriented assessment process, which takes a much broader look at the older person's circumstances. All parties would need to agree one common framework for the 'gate-keepers' to agree access to the partnership deal. Some agreed common assessment process needs to ensure that the eligibility criteria are implemented consistently in both the private and state arenas. Germany offers one example of where a state social insurance scheme and private LTCI work to the same national entry criteria.
- Local authorities would lose their existing broad autonomy to set local needs eligibility criteria.
- The likelihood is that shared national entry criteria would be more ADL-based and less individual-based than the current system. As discussed earlier, this has the benefit of offering transparency and 'fairness', but may not be as efficient at targeting limited resources on those most at need.
- The eligibility criteria would have to be comprehensive enough to cover people with dementia, whose care needs are not always definable in terms of ADL limitations.
- Whenever there was an interface between state-funded care and private/insurance-funded care, there would have to be a seamless boundary between the two periods.
- The arrangement would have to cover care at home as well as residential care, or it would create a perverse incentive again in favour of care homes.

- The choice of period of self-funded care would be crucial in determining the insurance risk, given that a certain proportion of older people can be expected to die within a specified length of time after entry to a care home.

It would be necessary to rebuild confidence in the LTCI system for this type of package to be attractive, given the long lead-time. The public would need to believe that the partnership 'deal' would last their lifetimes, and not just until the next general election. Since insurance companies would want to retain the right to review premiums every few years, this might tend to undermine people's confidence in their plans for the future.

LTCI and partnership deals in the US

The US Congress has adopted various initiatives to promote the purchase of LTCI such as a limited tax deduction for premiums, the Federal Long Term Care insurance Program for federal employees, and a consumer education campaign (Ahlstrom et al 2004a). Nevertheless, despite being the most developed market for private LTCI, it accounts for only about 10 per cent of the total money spent on long-term care.

The limited take-up of LTCI in the US has been investigated by Brown and Finkelstein (2004b). The study found that the typical policy purchased by a 65-year-old and held until death had a 'load' of 0.18 (i.e. that on average an individual would get back only 82 cents in expected discounted value benefits for every dollar paid in expected present discounted value premiums). Typical policies also covered only one-third of the expected present discounted value of long-term care expenditures. However, the authors concluded that the low uptake was not due to supply side factors. There were big differences in loads between men and women, at 0.44 for a policy purchased by a 65-year-old man and –0.04 for a 65-year-old woman. Yet there was no difference between the sexes in insurance coverage, suggesting that supply side factors did not account for the overall low uptake. The report also found more comprehensive policies available at comparable loads to the more limited policies that were actually purchased.

In related work, the authors suggested a demand-side explanation for the role of Medicaid in the low take-up of LTCI (Brown and Finkelstein, 2004a). It is estimated that a large part of the premium for LTCI pays for benefits that simply replace benefits that would otherwise have been provided by Medicaid. This 'implicit tax' that Medicaid imposes on private insurance policies arises because the private insurance policy has to pay first, even if the individual is eligible for Medicaid. In addition, private insurance reduces the chance of means-tested Medicaid eligibility because it protects assets. The study concluded that the provision of even incomplete public insurance can substantially reduce private insurance demand, and that government reforms to stimulate demand for LTCI were unlikely to have much impact. If these arguments are accepted, they would appear potentially to be relevant for the uptake of LTCI in England, where means-testing asset limits are higher than in the US.

The US does offer some examples of partnership and incentive deals that have been put into practice such as the LTC Partnership Program (Ahlstrom et al 2004a). This combines private LTCI with preferential access to Medicaid for those who have exhausted their insurance benefits. This system puts a ceiling on the amount of long-term care that is covered by the insurance policy and so the premiums become more affordable. When the

cover runs out, the policyholder then gets access to Medicaid without spending down all of their assets to the usual thresholds, although all income must still be devoted to care costs.

Four states have implemented the programme. The hope was that the scheme would help reduce Medicaid costs. However, there have been some concerns that wealthier people who would in any case have bought LTCI might have been signing up to the Partnership Program to gain earlier access to Medicaid. It is too early to say whether the anticipated savings to the public purse will be realised.

Two different models of scheme were developed, according to Ahlstrom (2004a).

- The **dollar-for-dollar model** (California and Connecticut) allows people to buy LTCI policies that protect a specific amount of their assets, for example, a policy with a maximum benefit coverage of $50,000 would protect $50,000 of assets in the case of Medicaid being claimed. Once the benefits of the insurance policy are exhausted, the beneficiary must use any remaining assets above the protected amount (that is, any assets above the $50,000 threshold) and income to pay for long-term care services. After such sources have been exhausted, the beneficiary then qualifies for Medicaid benefits.
- The alternative **total assets model** (as in New York) requires a user's LTCI to cover three years of nursing home care, six years of home care, or a combination of the two. The LTCI premiums are higher under this model, but it provides protection of 100 per cent of assets if users exhaust their policies and require Medicaid.
- Indiana's **hybrid model** offers a choice of either of these schemes with the dollar-for-dollar version offering some assets protection if a user purchases a minimum of one year's LTCI.

Most participants in the US partnership arrangement have yet to need long-term care, so a full evaluation is not possible. The introduction of the partnership schemes has at least had the collateral benefit of leading to improvements in regulation and product type for all LTCI products. Ahlstrom *et al* (2004a) found that the deal had not attracted large numbers of new purchasers of LTCI. The scheme does appear to have appealed to individuals with higher income and not to have reached those who would be likely otherwise to spend down to Medicaid thresholds. There has been some suggestion that it would be better to target the scheme on people who would not otherwise purchase LTCI.

The partnership schemes could nevertheless become more widespread following a vote by US House of Representatives in November 2005, which narrowly passed a bill to remove the ban on other states introducing partnership schemes.

Use of housing equity to fund long-term care

Chapter 12 (Section 4) of the Review looked at the potential role of housing wealth in funding long-term care. Fuller details are given in this section about the various products on offer.

The aggregate housing wealth of those aged 65 and over has been estimated at £1,100 billion (Actuarial Profession 2005). The same study argued that if 75 per cent of the population have inadequate income in retirement (Deloitte 2002), and 70 per cent of the retired population are homeowners (ONS data), then on the assumption that most of the 25 per cent with adequate income are also homeowners, that would mean some 45 per cent of the current retired population – or 4.3 million people – were homeowners with inadequate retirement income.

Traditionally, such people might think of downsizing by moving to a smaller home and releasing capital. But buoyant house prices have encouraged a new trend of using equity release products to gain access to property wealth without having to move house. In the context of funding long-term care, the question is whether this will provide a meaningful new source of ongoing mainstream funding for social care, and how the means-testing and benefits system can affect this possibility.

There are broadly two types of equity release mechanisms: mortgage schemes and home reversion plans. In each case there are various versions on offer.

Mortgage schemes

In this case, the provider lends a homeowner a lump sum and takes a mortgage charge on the customer's property. There are four main types of product (Actuarial Profession 2005).

Fixed-interest lifetime mortgages

Fixed-interest lifetime, or 'roll-up' mortgages, account for probably more than 90 per cent of sales. Interest is compounded at a fixed rate during the lifetime of the loan, with no repayments until the customer dies or moves into residential care. The capital and rolled-up interest are repaid from the proceeds of the house sale. There is usually a 'no negative equity' guarantee, so that the total amount owed is not greater than the sale price of the house. The providers differ in the fixed interest rate they offer and the maximum loan to value (MLTV) – the proportion of the property value which can be released as cash. A survey by the Actuarial Profession in November 2004 found a range of interest rates from 6.79 per cent to 7.49 per cent AER. This meant that the final debt on a £100,000 loan after 20 years would have ranged from £372,000 to £424,000. In June 2004, the MLTV on offer to a 70-year-old ranged from 22.5 per cent to 35 per cent. This would very likely be higher for an older person, whose life expectancy is that much lower. The combination of different

interest rates and MLTVs can have a big impact on the residual property value that passes to the owner's heirs on death. The Actuarial Profession survey found that, assuming a borrower aged 70, the relevant MLTV, a property worth £200,000 and annual house price inflation of 3 per cent, the residual equity remaining in the property after 20 years would vary between £79,000 and £212,000. The small print on such loans also varies in terms of early redemption penalties and market-based adjustments, which could be high.

Interest rates for lifetime mortgages have come down considerably since the November 2004 survey. One provider in December 2005 quoted rates varying from a lifetime tracker at bank base rate plus 0.99 per cent (5.49 per cent, and capped at 8.99 per cent) to lifetime fixed at 5.89 per cent. Compared to non-lifetime deals (for example, tracker loans and 15-year fixed loans) the interest rate differential is now around 0.50 per cent. At this level, providers argue that there is very little scope to reduce that differential further as this needs to cover: the no-negative equity guarantee; the cashflow cost as the lender does not receive any interest until death/a move occurs; and interest rate swap and breakage costs, as the loan has no fixed-term maturity.

Lifetime loans also have more onerous capital requirements on providers than normal home loans. Additional capital has to be provided upfront, equivalent to half the estimated rolled-up interest in the future, based on the life expectancy of the applicant at application. This means that to achieve equivalent returns to normal home loans, lenders have to charge higher rates. Providers have suggested that more favourable capital requirements could help lower the cost of this product.

Another type of roll-up mortgage is a Drawdown Mortgage. Instead of taking a single lump sum, it is possible to take smaller, regular amounts – for example, every month. This total debt then grows more slowly.

Variable-interest lifetime mortgages

In this case the interest rate is usually linked to the RPI or the provider's variable rate.

Fixed-repayment lifetime mortgage

A fixed amount is repaid at the end of the mortgage in this case, regardless of the length of the loan. Thus anyone living longer than expected will do better than with a roll-up mortgage. However, the loan will have been more expensive for the estate of anyone who dies earlier than expected.

Income reversions

Instead of taking a cash lump sum, an equity release product can offer a regular income. In practice, this is much less common because a lump sum can in any case be used to purchase an annuity.

Roll-up mortgages provide a very stark illustration of the impact of compound interest. Figures provided by the Financial Services Authority (May 2005) illustrate why the MLTV can look low to anyone who does not realise how a debt can grow (*see* Table 4, overleaf). With the no-negative-equity guarantee, and increasing life expectancies, a lender needs to be cautious.

TABLE 4: ILLUSTRATION OF THE IMPACT OF COMPOUND INTEREST ON FIXED-INTEREST LIFETIME MORTGAGE

Loan period (years)	Amount owed on an equity release lump sum of £45,000, with an annual interest rate of:		
	5%	7%	9%
5	£57,433	£63,115	£69,239
10	£73,301	£88,522	£106,532
15	£93,552	£124,157	£163,912
20	£119,399	£174,136	£252,199
25	£152,387	£244,235	£388,039

Source: Financial Services Authority 2005

Reversion schemes

In this case, the provider buys a share (up to 100 per cent) of the customer's home, but the customer continues to live in the property rent-free until the end of their life. The price paid for the stake in the property is at a discount to the market value. For example, £60,000 might be paid for a 50 per cent stake in a £250,000 house. The cash sum can be invested to create a regular income. The percentage of the stake's value that is paid out will be higher the older the person is when entering into a reversion scheme arrangement. On death, or a move into a care home, the property is sold and the reversion company receives the value of the share of the home that it bought, while the remainder belongs to the older person or their estate.

The provider assumes the risk of not knowing how long it will be until the property is sold, or what will happen to house prices and interest rates in the meantime. If the resident lives longer than expected, then the return to the provider is lower.

With reversion schemes the ultimate cost to the consumer can be excessive if house price inflation is high, resulting in equivalent APR interest rates (when calculated retrospectively) that are many times those charged for an alternative roll-up lifetime mortgage. One provider told this Review that it believed reversion schemes carried a potentially high risk of subsequent mis-selling challenges, in cases when the final cost had been excessive.

The market size

The equity release market has grown steadily since the early nineties, boosted by the introduction of roll-up mortgages in 1998. This is now the dominant product type. Reversion mortgages suffered a big set-back in 2004 with the withdrawal of the biggest provider (AMP), and the closure of the second biggest provider's direct sales force (GE Life) (Actuarial Profession 2005).

Overall business trends are illustrated in Tables 5 and 6 (opposite) by the figures from Safe Home Income Plans (SHIP), a company backed by leading providers who observe a code of practice regarding equity release plans. (Reversion schemes are still not regulated by the Financial Services Industry, as of December 2005.) The figures (which cover SHIP members,

TABLE 5: VALUE OF NEW BUSINESS IN THE EQUITY RELEASE MARKET, 1998 TO 2005

	Value of new business (£million)							
	1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
Lifetime Mortgages	6.3	84.7	297.4	359.2	651.1	1,032.0	1,151.8	1,048.9
Reversion Sales	121.0	155.4	226.8	213.0	200.8	129.4	40.5	54.6
Total	127.3	240.1	524.2	572.2	851.9	1,161.4	1,192.3	1,103.5

Source: Based on figures from Safe Home Income Plans (personal communication 2006)

TABLE 6: NUMBER OF NEW EQUITY RELEASE SCHEMES TAKEN OUT, 1998 TO 2005

	Number of schemes taken out							
	1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005 (Jan–Sept)**
Lifetime mortgages	182	2,647	9,300[1]	11,200[1]	16,048	23,893	25,302	16,775
Reversion sales	1,922	2,484	3,900[2]	3,700[2]	3,075	1,938	835	838
Total	2,104	5,131	13,200	14,900	19,123	25,831	26,137	17,613

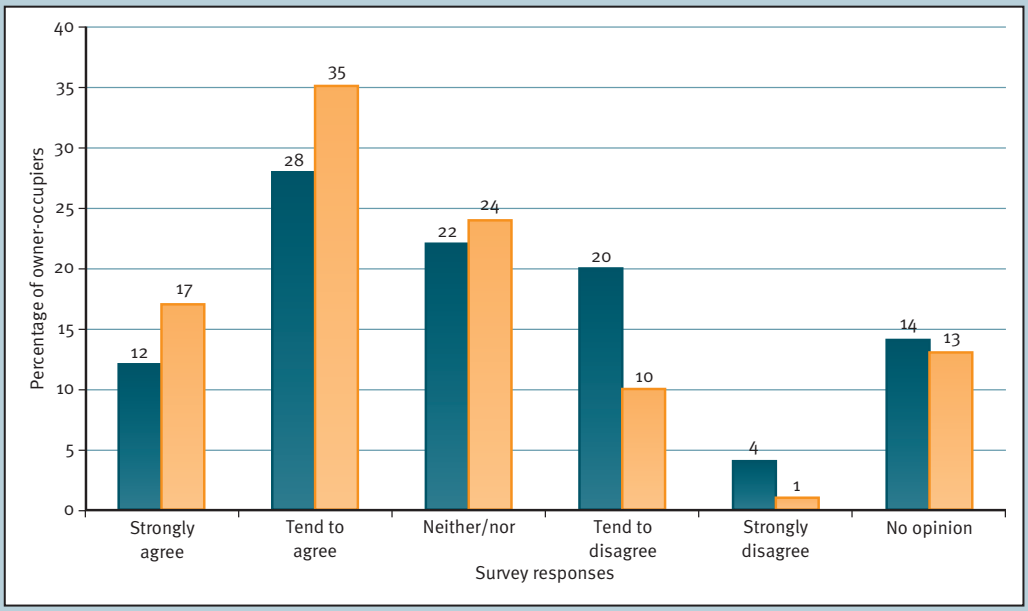
Source: Based on figures from Safe Home Income Plans (personal communication 2006)
[1] Assuming average plan of £32,000.
[2] Assuming average plan of £58,000.

representing 90 per cent of lifetime mortgages and the majority of reversions) demonstrate a big increase in new business, but also show that reversion sales fell sharply between 2002 and 2004, perhaps because of the very buoyant housing market. There is some expectation in the industry that reversion products will stage a come-back, and the latest figures (for 2005) suggest a modest rebound. The 2005 figures from SHIP also showed a significant increase in 'drawdown' business, with this type of more flexible equity release products gaining popularity with customers.

Public attitudes to equity release

A recent study into attitudes towards inheritance also looked in detail at people's opinions of equity release (Rowlingson 2005). It found that 68 per cent of all respondents said that they had heard of equity release schemes, and this figure rose to 78 per cent among owner-occupiers. Awareness peaked among those aged 50–59, and then declined. The lowest awareness was among those aged 80 and over, for whom equity release might well be the most relevant. The survey found that equity release was perceived as very risky and did not provide good value for money (though many people felt they could not answer the value question). The level of trust towards providers was very low. The survey results are shown in Figures 2 and 3 (overleaf).

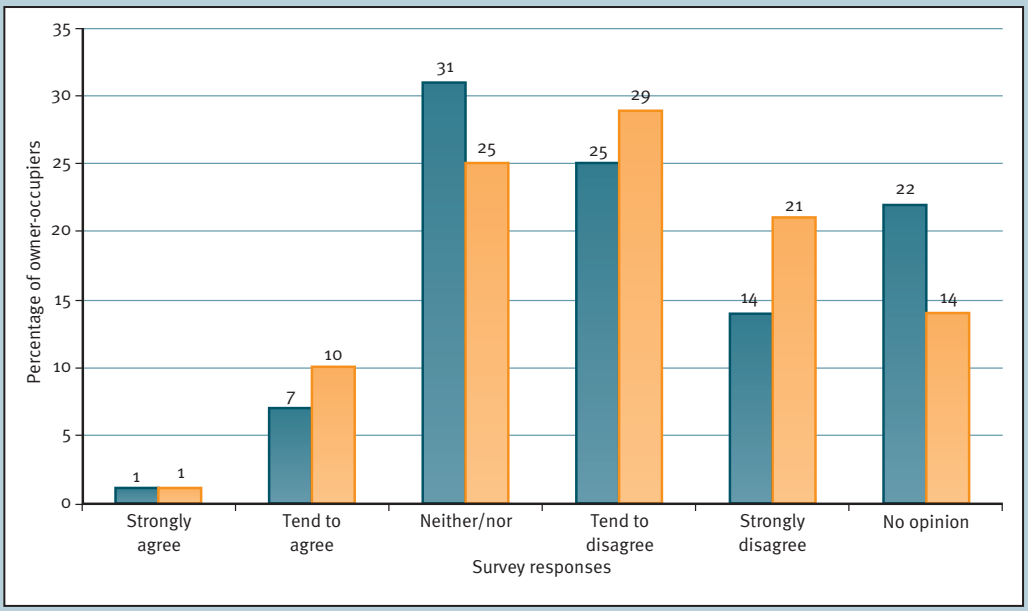
2 **PERCENTAGE OF OWNER-OCCUPIERS WHO CONSIDER EQUITY RELEASE SCHEMES TO BE DIFFICULT TO UNDERSTAND AND RISKY**



KEY
- Very difficult to understand
- Very risky

Source: Rowlingson 2005

3 **PERCENTAGE OF OWNER-OCCUPIERS WHO CONSIDER EQUITY RELEASE SCHEMES TO BE VALUE FOR MONEY AND WHO TRUST THE PROVIDERS**



KEY
- Good value for money
- I trust the providers

Source: Rowlingson 2005

The negative view that people have about existing equity release products contrasts greatly with their opinion when asked whether such schemes are a good idea in theory. In this case, the study found that 7 per cent strongly agreed, 55 per cent tended to agree, and 15 per cent neither agreed nor disagreed. Thus only 18 per cent tended to disagree or strongly disagreed (some 6 per cent had no opinion). So there appears to be scope to increase the use of equity release if the right products and providers are on offer.

Much of the scepticism disappeared when people were asked how they would feel about equity release schemes if they were run on a not-for-profit basis by a respected and trusted organisation. The emotional attachment that people have towards their homes did, however, mean that a few people said they would never consider using an equity release scheme, mainly because they wanted to bequeath their property intact to their children. However, it should be noted that the number of childless pensioners is set to double from 10 per cent to 20 per cent over the next 20 years (Pensions Commission 2004, cited in Maxwell 2005), so that there will be more older people without children to whom to leave the family home.

Is there a role for the government in equity release?

It is not widely known by older people that local authorities can provide a state-funded equity release scheme in certain circumstances. Under the Department of Health rules on charging for residential accommodation (section 55 of the Health and Social Care Act 2001 and associated regulations) councils can operate a 'deferred payments' scheme whereby they take a legal charge on a resident's main or only home instead of contributions towards the cost of the individual's care home costs. The aim is to allow people with property, but without income or other assets sufficient to meet their full assessed contribution, to have a legal charge placed on their property to meet any shortfall. Hence an older person is able to keep a home on admission to residential care and for the duration of the deferred payments agreement. The council pays the fees and the accrued debt rolls-up. When the person dies, the local authority then recoups the money when the house is sold. Unlike a commercial home equity release scheme, no interest is charged on the accumulated debt (until 56 days after the older person's death). For an older person, it thus represents an extremely attractive equity release scheme.

In 2003/4, the proposed deferred payment grant was £31.287 million for England. This was the last of a three-year period when councils received this grant to cover the start-up costs of implementing the scheme. The reasoning was that after three years some of the original applicants would have passed away, and the refunded accrued debt would be available to fund new deferred payments. It appears that no data has been collected which aggregates the total number of older people in England who have entered into a deferred payment arrangement with their local authority, or the total amount of debt under the scheme. Nor is there information on the average final amount that is owed at death by an older person on a deferred payments arrangement.

Similarly, there does not appear to be any information overall about the instances when deferred payment has been granted, what the eligibility criteria have been in practice, and how often this results in a property standing empty. Although relatively little money is involved, the policy raises a number of questions. If the home is left empty, should there be a time limit on the duration of a deferred payments scheme, on the grounds that someone who has been in residential care for more than a certain period is unlikely to return to live alone at home? On the other hand, how often is a deferred payment arrangement usefully being used to avoid making homeless another (non-partner) person such as a younger sibling when the home-owner moves into care?

Separately, the Regulatory Reform (Housing Assistance) Order 2002 gave local authorities powers to develop equity release loan vehicles to provide assistance for homeowners to

fund repairs or improvements to their homes. Take-up by local authorities has been variable across the country. More positively, there have been a few partnership schemes between the public and private sector, such as the Home Improvement Trust, which aim to provide equity release for homeowners with properties that are in poor condition or which would not qualify for normal commercial schemes.

The Joseph Rowntree Foundation (Hirsch 2005) has argued that there should be a state-backed national home equity loans subsidised scheme to help older people create an income which can pay for care costs. This would be modelled on the student loans system, with an income drawdown maximum, say, of £500 a week. The government would guarantee the loans, which would have a preferential interest rate at or below the base rate. Once again, the question of eligibility arises. For instance, there is the question of whether such a package should continue to be available to someone who has been in residential care for longer than a certain time, if this encourages more properties to be left empty.

A discussion paper from the ippr (Maxwell 2005) looked at broader arguments for and against government subsidies for housing equity release. It pointed out that returns to investment in housing are already taxed relatively lightly, especially because of the absence of capital gains tax on primary residences. A large portion of housing wealth is also 'unearned', and does not accrue because of the hard work of its owners, the report said. So it can be difficult on equity grounds to argue that the government should financially support housing equity release. The study does conclude that the government could play a role in extending the market to those currently excluded and improving consumer confidence. One proposal was that owners of previous right-to-buy properties could be helped to 'staircase down' by selling a share in the property to a registered social landlord (rather like a home reversion scheme). After the owner's death, the property could be rented out as social housing. This would extend the equity release option to some of those currently excluded. The market might also benefit from a standard 'stakeholder'-style product, with lower charges and lighter regulation, although providers argue that without a government subsidy it might be difficult for a state-backed system to offer better terms than are now available in the market.

The role of equity release and long-term care finance

The main limitation of using housing equity to fund long-term care is simply that few people have enough housing wealth to pay for several years of ongoing care. This raises the question of whether housing equity could instead be an appropriate way of funding the purchase of long-term care insurance (LTCI). Already, the purchase of immediate needs annuities to cover care home costs is often funded by the proceeds of a house sale; could this link be extended to use a housing equity release scheme to fund pre-paid insurance products?

In the US, the American Homeownership and Economic Opportunity Act of 2000 introduced a scheme whereby a government-backed reverse mortgage program (the Home Equity Conversion Mortgage program) will provide a financial incentive to homeowners who use their entire loan payout to purchase a qualified long-term care insurance policy (Ahlstrom 2004b). The law waived the up-front premium on government-insured reverse mortgages in this case, equal to 2 per cent of the home value or the loan limit. The

attraction for the state was to reduce the number of people who 'spend down' to the level at which Medicaid becomes payable. As of December 2005, the federal agency that has authority over the affected program, the Department of Housing and Urban Development (HUD), has yet to release regulations on this issue. The agency must first promulgate a proposed rule, then accept public comments, and ultimately issue a final rule responding to public comments. Until these actions are taken, no private entities may offer a reverse mortgage/LTC insurance policy product, so there are no such schemes so far.

Ahlstrom (Ahlstrom 2004b) outlined some potentially unattractive features of such an incentive: i) a mismatch in terms of preferred timing, because the optimal time to buy LTCI is likely to be different to that for taking out a reverse mortgage; and ii) a mismatch in terms of the population, in that reverse mortgage borrowers tend to be single people with low income and few other assets, whereas those taking out LTCI are wealthier and do not need to get access to housing equity to pay for LTCI; iii) some people may need more flexibility in the use of the payout from the reverse mortgage, even if part of it might go towards LTCI.

In the UK, advisors say that few equity release schemes have been used to buy pre-funded long-term care insurance policies, partly because the rise in popularity of equity release has coincided with the decline in the pre-funded LTCI market. Linking two products, both of which are perceived by consumers to be very expensive, is unlikely to create an attractive package.

The Actuarial Profession (Actuarial Profession 2005) has suggested some ways in which a package service might be developed. For instance, the equity release client could be offered a housing maintenance service. Going a step further, personal care services as part of the package could be a possibility, (although it is difficult to see why a mortgage lender would want to enter into an arrangement designed to keep an owner longer in the property). The next step would be for the equity release provider also to offer the LTCI product. It suggests that for reversion schemes, for instance, insurance for domiciliary care could be charged at full cost but insurance for residential home care could be discounted to reflect the releasing of the house and the return of finance that such a move would entail.

In theory, housing equity can be used in different ways at different stages of decline. Equity could be released to provide support (possibly insurance related) while receiving care at home. On entry into residential care, the home could be sold, and the residual housing equity used to purchase an immediate needs annuity.

A radical approach to the means-testing of housing assets

Desmond Le Grys, an actuarial consultant, has put forward the idea of a state-sponsored equity release scheme that would operate through a so-called Equity Release Mechanism Agency (ERMA) (Le Grys 2005). A person needing care would receive a series of loans from the ERMA to cover care costs either at home or in residential care. ERMA would take a charge on the house and the loans (and any interest) would be rolled up. The scheme would be flexible enough for an older person to take a small income to give to a carer, and loans could be given to cover respite care. The total loan would be repaid on the death of the person, or the surviving spouse. A central agency would administer the system, which would be underwritten by the state.

The crucial departure from the present funding system is that housing assets would be brought into the financial assessment and charging net for state-funded care, even when care was being provided at home or a spouse was still resident after one partner moved into a care home. Thus the state would always have a claim on housing assets, but ERMA would provide a cost-effective mechanism for all older people to release the value of their housing equity.

The state could use such a scheme as part of a partnership arrangement in various ways. Depending on the generosity of the system, public funds could be made available for one of several options:

- to pay a percentage of the care costs
- to pay all the care costs after a certain period, for example, three years
- to pay all the care costs (apart from accommodation costs) after the self-funder has spent more than a certain amount on care (say £50,000 from private income or assets)
- to pay all the care costs after the older person had eroded their total assets (including savings) down to some specified threshold level
- to pay all the care costs after the older person had spent a proportion of their estimated assets (this formula removes some of the disincentive to save). A very valuable incentive to users would be to charge zero interest on the accumulated loan, or to levy a reduced interest charge. The incentives could also make the package more politically acceptable, given the greater claim by the state on housing wealth as a source of funding for long-term social care. The state would bear the running expenses and the cost of any subsidised interest rate.

It would be also be necessary to ensure that the receipt of ERMA loans would not incur income tax or affect eligibility for means-tested state benefits.

If the value of the accumulated loan was greater than the value of the house, then the person would remain living in the property and would thereafter be means-tested for benefits. Anyone not owning a property would immediately be eligible for means-tested social care.

As with all partnership arrangements, there would have to be an agreed entry point into social care, which would have the disadvantage of meaning everyone would need to have some kind of interaction with the state (otherwise self-funders would not be able to claim the free care after, say, £50,000 was spent, or at whatever point the state had agreed to step in). In addition, the (say) £50,000 would have to be spent on agreed forms of social care.

From the state's point of view, the financial equation balances the extra private financing of social care through the release of housing equity against the cost of the interest-free loans, plus the cost of providing free social care after a certain stage to those people who, under the present system, would continue to be self-funded. The justification for bringing more housing equity into the equation would be that this accumulated wealth is untaxed at the moment until inheritance tax. The drawback of this scheme would be having to broaden the role of the local authority/state in terms of the number of people with whom there would have to be some interaction. Issues to resolve would also include whether (under some partnership models) local authorities would find ways to make the self-funding period last as long as possible by underestimating the amount a care a person

needed and how much local autonomy would remain with councils in terms of setting needs eligibility levels. It would also be necessary to specify in great detail what services counted as social care.

The overall impact of this funding arrangement would be to force many more people to use up housing wealth if they needed long-term social care. People owning property would be asked to pay more than under the current system. On the other hand, no one would be compelled to move out of their homes or to sell them. It would be the heirs of the estate who would find their inheritances had been reduced.

Vouchers for care

Chapter 12 (Section 4) of the Review also briefly outlined a proposal by Counsel and Care for a system similar to the existing voucher scheme for employer-supported child care. This would introduce income tax and national insurance exemptions on employee contributions towards the costs of care and support for older relatives. Staff would have the option of contributing a weekly sum (up to some maximum) in return for vouchers that could be used by the older person to purchase care services from a wide range of accredited and approved sources. As with the childcare vouchers, the employers would meet the administrative costs of the scheme, and would also be exempted from employer national insurance payments on the total amount contributed by their workforce.

A key question is whether such a scheme would bring new money into the system, or just subsidise existing private funding of social care. Would long-term care vouchers mean that people stayed in the workforce rather than giving up jobs to care for older relatives? Would tax breaks increase the amount of money that the relative made available to pay for care? Can the parallel be drawn with child care, given that children are not independent economic individuals in the same way that older people are? Most important would be the decisions about eligibility for such vouchers. Would they be available for any older relative over a certain age, or would there be some gate-keeping procedure to determine that the older person needed domiciliary care? (It might be hard to make a case for the tax break to be available for care home funding.)

Significantly, 3 million people already combine their caring responsibilities with full- or part-time employment (Counsel and Care 2005). According to Carers UK, as cited by Counsel and Care, 186,000 women in part time employment are caring for 20 or more hours a week, compared to 32,000 men; one in six women working part time, and one in eight women working full time, are carers. General Household Survey 2000 data (as reported in OECD 2005) include an age break-down of informal carers in the UK: 35 per cent of informal carers are aged 16–44, 45 per cent are aged 45–64, and 20 per cent are aged 65+. So the majority of carers are of working age, and might be encouraged to work longer hours, or return to work, if tax breaks were made available on contributions to care. Research by the Department of Work and Pensions into factors affecting participation of older workers in the labour market did suggest caring responsibilities were a reason for people to leave the workforce (Irving *et al* 2005).

Counsel and Care also argues that this system would help to deliver the low-level preventive agenda by providing care and support to older people who choose to remain at home and who do not currently qualify for formal care services as resources are targeted at those with the highest level of need. It could also raise standards of care (for example, from personal assistants) through a third-party accreditation system such as exists in child care; this could provide a means of ensuring that service providers are checked for any

criminal record etc (something that could also be implemented in many other social care models). A balance would need to be struck between the requirement of flexibility (in terms of meeting the diverse requests from older people) and some control over the type of services that would qualify for inclusion. Counsel and Care suggests that funding from an employee benefit could be used to pay for low-level services such as cleaning and home maintenance, domiciliary care, telecare and respite care.

Various implementation issues arise with such a system, some of which have been raised in the context of the child-care vouchers. Any scheme that is only open to employees clearly disadvantages the self-employed and the unemployed. Similarly, since 20 per cent of carers are over the age of 65, it might seem unfair not to offer them the same incentive to buy in more care. Overall, it is arguable whether the tax and National Insurance breaks should be available at the higher tax rate, or would be best limited to the basic rate. One key decision would be the maximum weekly amount permitted as a contribution. For instance, it is difficult to see how a basic rate tax break on, say, £50 a week of expenditure would be enough to persuade someone back into work. However, the maximum contribution level could, perhaps, be inversely linked to earnings so that low earners benefited most from the scheme.

In a very rough calculation, Counsel and Care estimates that if 150,000 employees signed up to contribute £50 a week to an older person's care costs, the approximate cost to the government in lost income tax and National Insurance would be £195 million.

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