King's Fund

Background Paper

Download full report, *Securing Good Care for Older People*, from www.kingsfund.org.uk/publications

Author

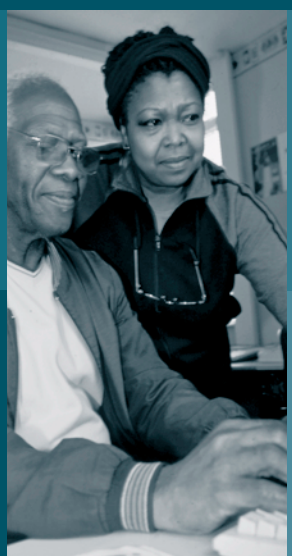
TERESA POOLE

Date

2006

wanless social care review

Private Expenditure on Older People's Social Care



KING'S FUND
11–13 CAVENDISH SQUARE
LONDON W1G 0AN
Telephone 020 7307 2400
www.kingsfund.org.uk

wanless social care review

PRIVATE EXPENDITURE ON OLDER PEOPLE'S SOCIAL CARE

Teresa Poole

King's Fund

This is one of a series of appendices to *Securing Good Care for Older People*. Download full report from www.kingsfund.org.uk/publications

First published 2006 by the King's Fund.

Charity registration number: 207401

www.kingsfund.org.uk/publications

Typeset by Andrew Haig and Associates
Front cover image by Sara Hannant www.sarahannant.com

Paying privately for care

Self-funders are usually defined as people who receive no funding from the state towards their social care, apart from non-means-tested state benefits such as Attendance Allowance. Separately, they are likely to receive a state pension and other benefits which are not care-related, but some of this money may be used to pay privately for care. There are several situations in which people can find themselves contributing income and/or savings towards long-term care.

- A care home place can be privately arranged with little or no contact with the local authority and then fully self-funded.
- A care home place can be arranged through a local authority and, after a means test, fully or partly self-funded by the older person.
- A care home place can be state-funded, with relatives paying 'top-up' fees.
- An older person can receive domiciliary care which is arranged by the local authority and which, after a means test, is fully or partly funded by a user's income or savings.
- Private funds can be spent on domiciliary care which is privately arranged, either through an agency or directly with a care worker.

The data that is available on self-funded care is far less comprehensive than for state-funded care. Also, much of the information that *is* available on self-payers covers all adults rather than just those over the age of 65. Any estimate of the total private expenditure on social care, and particularly community-based care, is therefore, at best, an indication.

Self-funded care home places

Since 1988, the number of self-funded places in private and voluntary care homes for older and physically disabled adults (including those under 65) has varied between 100,000 and 125,000 for the whole of the United Kingdom, with the number level at around 120,000 for the past two years (Laing & Buisson 2005a). This represents 25 per cent of all care home places (public, private and voluntary) and 32 per cent if only the independent sector (private and voluntary) care homes are considered. Given that around 84 per cent of care home places in the United Kingdom are located in England, the number of self-funded places in England can therefore be estimated to be approximately 100,000. Using an average weekly figure of £370 for residential care (not including any free nursing element), this would produce a total volume of care of around £1.9 billion a year, of which the big majority is consumed by older people.

Laing & Buisson's figure does not include people whose placements are arranged by the local authority but who do not receive any state funding; this is comparatively rare, but does happen for instance when the older person has no relatives or friends to assist. It also does not include people who are making a contribution after means-testing. In 2003/4, these categories of self-funders appeared to have paid charges totalling £1.38

billion (based on figures in Department of Health 2005b). Also, there are the increasing numbers of people whose care home fees are partly met by third parties 'topping' up what the local authority is willing to pay. The Office of Fair Trading's (OFT's) report into care homes for older people in the United Kingdom (Office of Fair Trading 2005) found that 44 per cent of residents received support only from the local authority, 24 per cent received local authority funding that was then 'topped up' by third parties, and 32 per cent were self-funding. This means that one-third of people receiving any local-authority funding also rely on top ups from third parties, strengthening the argument that the amount that local authorities are willing to pay is often not adequate to buy a level of care that the resident is happy with. There does not appear to be any evidence available about the total amount paid in these top-up fees.

There is clearly a discrepancy between the OFT's figure of 32 per cent of all older people in care homes being self-funded, and Laing & Buisson's 25 per cent figure (which also includes those under 65). However, a possible rough estimate for the amount of private funding of care home places can be reached from the £1.9 billion and £1.38 billion mentioned above, which would total £3.28 billion (for 2003/4), in addition to which would be the total value of the top-up fees paid by third parties that are not arranged through the local authority.

One common complaint among self-payers in care homes is that they are sometimes charged more than local authority funded residents for the same level of service, thus subsidising state-funded occupants. Care home managers argue that this is necessary because the fees they receive from local authorities are inadequate. The evidence is not clear-cut. A random sample survey by Laing & Buisson in 1999 of 600 care homes throughout the United Kingdom showed that privately paid elderly care-home fees were £20 to £40 per week more on average than the local authority contract price (Wright 2003). Another study (Netten *et al* 2001) found that, while previous work had indicated that self-funders tended to pay a premium, by the time of the research, self-funders appeared to be more likely to be charged the same as publicly funded residents. The most recent work suggests that there *is* a persisting problem. The OFT research found that around one in five homes were charging self-funders more than authority-funded residents for a similar room and similar care (OFT 2005). An industry survey (Laing & Buisson 2005a) states that self-pay fees are now 'typically £50–£100 or more higher than local authority fees on a similar service and similar amenity basis'. It states that many care homes rely on this cross-subsidy to produce a reasonable return on investment. One specific example was provided by an industry source. For the year in question, Liverpool City Council paid average care home fees of £367 a week, but it cost an average £426 a week for the provider to supply the service, resulting in a shortfall for the provider of £1.2 million a year on its local authority contracted residents.

A recent case brought to Age Concern involved someone who had been temporarily covered by a local authority contract while her house was sold. The contract price for the local authority was £356 a week, and the user repaid this amount in full. But when the house was sold and the user became a self-funder with her own contract, the price went up to £520 a week. (In both cases, the fee excludes the nursing care band.) Several similar reports were provided to this review by industry sources. Table 1 shows three examples from care homes where there were approximately 50 per cent private-pay residents. From the self-funding users' point of view, set against the higher charges would be a self-payer's

TABLE 1: CARE HOME FEES FOR LOCAL AUTHORITY FUNDED RESIDENTS AND SELF-FUNDED RESIDENTS

Care home fees (per week)	Somerset	Surrey	East Sussex
Local authority base fee Private fee	£464 £597	£566 £785	£436 £597
Difference	**£133**	**£219**	**£161**

Source: Industry source

likely ability to claim up to £60.60 a week in higher rate Attendance Allowance, which is not available to state-funded residents.

Underpinning the question of how much money is privately being spent on care home services is a more fundamental question of whether the residential home environment is the correct setting for these older people who are usually making choices about their social care without any assistance from disinterested parties. A study of self-funders (Netten and Darton 2003) found that in almost all settings, there was evidence of a lower level of physical dependency among self-funded residents than among publicly funded residents. This was true in terms of mobility, activities of daily living and continence. Half said that walking to the shops and carrying back shopping had not been a difficulty, and around half of those with gardens reported being able to do their own gardening without paid or unpaid help right up to the point of admission. There were similar findings with respect to cognitive impairment: a significantly higher proportion of self-funded residents in both residential and nursing homes were identified as entirely cognitively intact (27 per cent overall) and a lower proportion severely impaired (25 per cent overall) than publicly funded admissions (20 per cent and 35 per cent respectively).

One study estimated (Netten *et al* 2001) that around 21 per cent of self-funding residents need not have been admitted, given the assumption that they could have been maintained in the community at the same level of dependency as publicly funded residents. For instance, less than half of the self-funders in nursing homes had been admitted from hospital, compared with nearly two-thirds of state-funded residents.

If a significant proportion of self-payers are moving into residential care unnecessarily, then a lot of older people seemingly are not receiving adequate assessment, support and information about alternative care options (Robinson and Banks 2005). Local authorities are required to assess the care needs of any older person who may need care services where a person's circumstances come to the attention of the authority. Even if an older person will be self-funding, they are supposed to be advised about what type of care is required and the services available. In practice, various studies (Wright 2002) have found that local authorities avoid carrying out needs assessments of people whose financial assets are clearly outside the means-testing thresholds. This situation is exacerbated by the self-funders themselves being unaware that they have the right to a local authority assessment if they want it. The alternative of an assessment by a care home provider is hardly disinterested, as the care home clearly has a vested financial interest in admitting a self-funding resident (Wright 2003).

The Netten and Darton study found that a full local authority assessment had been conducted in 54 per cent of cases of self-funders (Netten and Darton 2003). For about half of the older people who were not assessed there was no evidence of any contact with social services. Even when a care home place might be the most suitable choice, self-funders often have little support in selecting a care home and setting up a contract. In its survey of residents, the OFT found that only 27 per cent of self-funders had received information about care homes from their local authority (Office of Fair Trading 2005). The OFT has recommended that self-funded older people with an assessed need should have access to the same advice, guidance and assistance on choice as older people receiving public funding.

Only a minority of self-funders secure the protection of a local authority contract. Wright (Wright 2003) found that only one in four (23 per cent) of responding authorities were prepared to make a continuing contract for a self-funding resident on request. The majority did so only in exceptional circumstances, such as when a person with poor mental health had no relative or friend involved.

The standard of information provided directly to self-funders by care homes and the wording of contracts was also of concern. The OFT found in its 'mystery shopper' exercise that more than one in ten care homes failed to provide basic price information, even after persistent prompting (Office of Fair Trading 2005). Other care homes did not provide information on what was included in the fees, extras services available and simple contractual information. In about a third of cases it proved impossible to get the care home to provide the terms and conditions for residents, or any details of the contract that any new resident (or representative) would have to sign. Even when information about contracts and terms and conditions was available, this was only available in printed form in 12 per cent of cases. Such information would seem to be absolutely necessary for anyone making a decision about a care home. Of the contracts that were analysed, nearly three-quarters had fee-related terms that were either unfair or unclear, and nearly half were unclear about who should pay what amount.

Self-funding care home residents are therefore spending significant sums on residential and nursing home care, but are doing so in a culture that often does not provide them with the basic information necessary to make informed choices about their care options. The research quoted above suggests that perhaps one-fifth or more of self-funding residents do not need to be in care homes at all, and this proportion would probably be even higher if alternative services models including telecare and extra care housing were more readily available (See Background Papers 7 ('Telecare') and 8 ('Housing options') in the Appendix.)

Self-funded domiciliary care

There is relatively little information about the market for privately purchased home care, both in terms of numbers of hours and total amount spent by consumers. Nor are there details of what tasks are carried out, and whether (as might be expected) these are less narrowly focused on personal care tasks than with state-paid care. The data which is available usually assesses all home care, not just that for the over 65s. It also tends to include only self-funded care contracted through local authorities and independent agencies, and does not cover care workers who are directly employed by the older person.

'Self-funded' in these studies almost always refers to care that is wholly privately funded. It therefore does not include local authority funded home care for which the means-tested recipient pays a part or whole contribution through charges. Regarding the latter, Department of Health figures (Department of Health 2005b) indicate that around £160 million was contributed by older people in such charges and fees for domiciliary care in 2003/4.

According to Laing & Buisson's Domiciliary Care report (Laing & Buisson 2005b), there is uncertainty about whether the volume of home care purchased privately is growing or declining, although some of those surveyed did report demand was increasing. The report (*see* Table 2) estimates the number of hourly charged, overnight and live-in home care hours that were privately funded to have been approximately 854,000 hours a week in 2004 in England, of which local authorities provided 10,000 hours a week. It estimated the total annual value of this privately purchased domiciliary care as approximately £417 million. The 854,000 hours a week was split between 318,000 hours of hourly paid home care and 536,000 hour of sessional or live-in care. Overall, private purchasers account for 20 per cent of the total home care market in England. Some 23 per cent of the independent sector's (agencies) total provision of £1,789 million worth of home care was to private purchasers, worth £411 million. No current estimate is given by Laing & Buisson for the proportion of the home care that is going to customers aged 65 and over, but it is assumed that it is the large majority. Similarly, no estimate is given for the amount of domiciliary care that is purchased direct from care assistants.

A different picture is presented by two surveys that the UK Home Care Association (UKHCA) has conducted with its members. This found an unexpected decline in the number of privately purchased hours of home care in England (McClimont and Grove 2004). A reduction was found both for i) the proportion of home care from all sectors that was purchased privately, and ii) the absolute number of hours of privately purchased home care. The surveys covered domiciliary care for all adults, but the UKHCA has typically found

TABLE 2: AMOUNT AND VALUE OF PRIVATELY PURCHASED DOMICILIARY CARE, 2004

	Number of hours per week (thousands)	Percentage of total home care market in England	Value (£million)
Hourly paid			
Independent providers	308	7	188
CSSR in-house providers	10	~ 0	6
Both provider sectors	318	7	194
Sessional or live-in			
Independent providers	536	13	223
CSSR in-house providers	–	0	–
Both provider sectors	536	13	223
Total hours			
Independent providers	844	20	411
CSSR in-house providers	10	~ 0	6
Both provider sectors	854	20	417

Source: Laing & Buisson 2005b

TABLE 3: PREVALENCE OF PRIVATELY PURCHASED HOME CARE IN ENGLAND

	2000	2003	2004
Private purchase as % of all home care delivered by independent providers	40	27	18
Private purchase as % of total home care delivered by all sectors	25	No estimate	13

Source: McClimont and Grove 2004

in the past that around 90 per cent of the total was destined for older people. The results of the UKHCA surveys in 2000, 2003 and 2004 are shown in Table 3.

The UKHCA's estimate of total privately funded home care in England in 2004 was around 500,000 hours a week, including care from independent providers, local authorities and any other sources. The equivalent estimate from the 2000 survey was approaching 1 million hours per week. Thus the amount had halved. (Neither figure includes nursing services.) This result was the opposite of what might have been expected, given both demographic factors and tighter local authority eligibility and funding criteria which would have been expected to increase the amount of privately purchased home care. (As with Laing & Buisson, these figures do not include any care hours privately purchased directly from a care assistant rather than through an agency.) Another trend clearly demonstrated by these figures is the sharply higher proportion of domiciliary care that is now purchased by local authorities from third party independent firms, after proving a cheaper option for social services departments than providing services in-house. The detailed estimates are shown in Table 4.

TABLE 4: ESTIMATE OF TOTAL WEEKLY HOME CARE HOURS BY SECTOR IN ENGLAND, 2004 AND 2000

Sector	Hours for 2004 (figures from 2000 survey)	Percentage for 2004 (figures from 2000 survey)
Local authority direct provision (Department of Health data)	1,043,200 (1,324,400)	28 (38)
Purchased by local authorities from the independent sector (Department of Health data)	2,069,800 (1,354,000)	55 (37)
Privately purchased from the independent sector	499,970 (948,653)	13 (26)
Purchased by the NHS from the independent sector	168,060 (66,373)	4 (2)
Total	**3,781,030 (3,693,426)**	**100**

Source: McClimont and Grove 2004

The UKHCA cautions about making very direct comparisons between its different surveys. The higher representation of sheltered housing and voluntary sector providers among respondents to the 2004 survey will have contributed to the decline in self-funded home care, as they tend to provide a smaller proportion of private care. Nevertheless, the association believes the survey results demonstrate a significant trend, even if the precise figures are not accurate. It suggests a number of reasons for the decline.

- The survey drew responses from a different set of providers. For example, the proportion of voluntary and not-for-profit providers more than doubled. Many of these providers may offer services only to local authority contracts.
- Providers may have been concentrating scarce labour resources on fulfilling contracts with local authorities, which are buying in more hours. This has meant lower available capacity for privately purchased care. One of the challenges for someone wanting private personal care is the shortage of available carers. Some of the unmet private demand will have been redirected to unstructured markets, such as direct purchase from carers, of which there are no good estimates.
- People in need of services but no longer eligible for public funding may not be able to afford to purchase their own care or are 'doing without' for other reasons. This would mean a high level of unmet need.
- The cost of privately purchased care may have increased (as a result of regulatory standards, higher wages and so on) to a level where people are not prepared to buy it or are buying substantially less.
- People previously receiving publicly funded services may not actually have needed them.
- People may be becoming generally fitter and need services only for shorter, more intense periods, so local authority funding covers a greater proportion of the market need. This contradicts our assumptions about compression of morbidity in the Review's model (that is, that there is actually a relative expansion of morbidity).
- There may have been an increase in the number of people relying on 'informal' care by friends and relatives.

Some further evidence is provided by the General Household Survey 2001. It asked people over the age of 65 if they had used private domestic help in the past month – irrespective of whether it was purchased through an agency or directly. Grossing up the results for the older population of England as a whole suggests that around 650,000 people paid for private help in the home. However, the scope of 'domestic help' is wider than personal care services and would have included non-personal care such as cleaning. Only around 332,000 people had self-reported ADL or IADL dependency, and might therefore be most likely to be purchasing personal care rather than general home help. Those who had paid for help were asked about the frequency of the help, with the following results: every day (8.6 per cent); two or three times a week (17 per cent); once a week (57 per cent); and less often (17 per cent). This means that only around 2.7 per cent of all older people were paying for private domestic help more than twice a week, and only 0.9 per cent had daily paid help – the categories that are most likely to include people who privately purchase intensive home care packages.

A survey of 2,000 randomly chosen older people (Stoddart *et al* 2002) found that 10.7 per cent were privately purchasing domiciliary care, but did not investigate the number of hours per week purchased or where it was being purchased from. This is in line with the 10.4 per cent figure from the General Household Survey for private domestic help (of any sort).

The English Longitudinal Study on Ageing (Banks *et al* 2004) looked at the reported source of help for people over the age of 50 reporting difficulty with one or more ADL, IADL or mobility function. Paid help was used by 1.6 per cent of those aged 50–59, 3.3 per cent of those aged 60–74, and 16.4 per cent of the over 75s. There were no details of the number of hours purchased, nor of the types of support activities undertaken (although these answers follow on from questions about ADL need).

It can be cheaper to employ a care assistant directly rather than going through an agency, although there can be administrative issues such as insurance, tax and national insurance. An unknown proportion of private carer workers are in the 'grey market', earning cash in hand. The Domiciliary Care report (Laing & Buisson 2005b) reports that the average independent sector provider charge for weekday daytime home care in England was £11.17 an hour for private purchasers in 2004. However, the pay rate for the care workers employed by a provider was between £6.38 and £7.62 an hour depending on day/night/weekday/weekend work. These latter figures provide a guide to what a private employer might pay. As always, regional variations were significant.

It is unsatisfactory that the information on the private purchase of domiciliary care is so incomplete and uncertain. The United Kingdom Home Care Agency's (UKCHA's) 500,000 weekly hours for self-funded domiciliary care is clearly at odds with Laing & Buisson's 854,000 hours. Nor does there appear to be robust evidence for the total amount spent by those directly employing carers. Any estimates of the amount spent on private domiciliary care are therefore based on incomplete information. As an initial guide, one can include the £160 million paid to local authorities through charges, and the £417 million Laing & Buisson figure, plus the unquantified expenditure by those who employ their carers directly.

Summary of public and private expenditure

Given the inadequate data, any aggregated estimate is very uncertain. Tables 5 and 6 opposite pull together the estimates mentioned earlier, with the further problem that they do not always refer to the same year. No estimates are made for missing data, in particular the total value of 'top ups' and directly contracted domiciliary care. So this will be an underestimate. The two totals cannot be aggregated because this would lead to double-counting. For example, self-funders often use Attendance Allowance to part-fund care home fees or domiciliary care.

The Review also produced estimates of the private purchase of home care, according to the five dependency groups used in its model. The difficulty with all attempts to assess privately paid home care is to distinguish between private *care* and private domestic help. The English Longitudinal Survey of Ageing (ELSA) gives specific information on uptake of private home care in response to ADL dependency. The *Health Survey for England* (HSE) 2000 gives information about intensity. Table 7 reports the Review's estimates (for older people).

TABLE 5: STATE EXPENDITURE ON SOCIAL SERVICES FOR PEOPLE AGED 65+

Department of Health net expenditure on personal social services for older people (2004/5)	£6.3 billion
Attendance Allowance and Disability Living Allowance (care component) for 65+ (2004/5)	£3.7 billion
NHS expenditure on long-term care for the elderly (PSSRU model figure) (2003)	£3.0 billion
Total	**£13.0 billion**

TABLE 6: PRIVATE EXPENDITURE ON SOCIAL CARE FOR PEOPLE AGED 65+

Self-funded care home places	approx £1.9 billion
Charges paid to local authorities towards care home fees (2003/4)	£1.38 billion
Self-funded domiciliary care 2004[1]	£417 million
Charges paid to local authorities towards domiciliary care (2003/4)	£160 million
Total	**£3.86 billion**

[1] Laing & Buisson 2005b

TABLE 7: PRIVATELY FUNDED HOME CARE, 2002/3

	Dependency group[1]					All
	Group 0	Group 1	Group 2	Group 3	Group 4	
Number of recipients (thousands)	108	115	31	25	10	290
Input per recipient (hours per week)	2.9	3.7	3.7	3.7	8.4	2.9
Total hours per week (thousands)[2]	317	432	116	93	85	1,042
Total annual private expenditure at £12.70 per hour[3] (£million)	210	286	77	62	56	690
Total annual private expenditure at £9.40 per hour[4] (£million)	155	211	57	45	42	510

[1] For a description of dependency groups, *see* Chapter 2 of the Review.
[2] Figures are liable to rounding errors.
[3] Hourly rate assumed in Review model.
[4] Average hourly rate from Laing & Buisson 2005.

The charging and means-testing system

The eligibility of an older person for state-supported social care depends on the individual's income and wealth, including home-ownership. The current means-testing framework restricts state funding to those with relatively low financial means, something that often comes as a surprise to older people who have assumed that social care for a frail older person with dementia or severe arthritis will be provided by the state in the same manner as NHS-funded health care. If the assessed person's assets and income are too high to qualify for state funding for any type of social care, then they are free to choose and pay for social care privately, but will get no direct state financial support.

In broad terms, nursing care is free, but in England the other costs of both residential care and care in the community are all means-tested, including the price of personal care. The exception is NHS continuing care, which is fully funded.

The means-testing system, and the inter-relationship between state-funded social care and the receipt of state benefits, are complex. State support for the costs of an individual's social care can have an impact on the state benefits that the older person receives. Similarly, many state benefits are taken into account when assessing income in the means-testing process for social care.

Free nursing care

Following the Royal Commission report (Royal Commission on Long-term Care 1999), the government removed an anomaly that had meant that elderly people were means-tested for NHS nursing care in care homes, but not in other settings. Since 1 October 2001 the NHS has therefore paid for the costs of registered nurse time spent on providing, delegating or supervising care in all settings – that is, in a care home, nursing home, or in one's own home. It does not include any time spent by any other personnel such as care assistants, who may be involved in providing care, although it would include any nurse time spent in monitoring or supervising the care that is delegated to others (The Health and Social Care Act 2001).

The free nursing care is not means-tested, and usually results in lower fees for people who are paying all or some of their residential care home costs and who are receiving nursing care. (Since 1 October 2001, the NHS has also paid for any continence aids needed by self-funding residents of care homes.) Receipt of free nursing care does not affect social security benefit entitlements, including Attendance Allowance or the Disability Living Allowance care component.

In order to qualify, the older person must first be assessed by a registered nurse and found to be in need of nursing care. This includes those people who are self-funding and who

entered care homes without any involvement of, or prior assessment by, the local authorities. For care home residents, the assessment determines the level of nursing care needed and one of three levels of support is then offered (2005/6 figures):

Low	£40 a week (with some flexibility)
Medium	£80 a week
High	£129 a week

The payments are made direct to the care homes or the local authority, and individuals do not themselves receive the money. Self-funding individuals who are receiving nursing care should be better off financially because the net fees that they are then expected to pay are lower. However, in 2002 a package of measures had to be introduced to stop some care home providers taking advantage of the government's NHS-funded nursing care initiative by artificially raising fees for residents (Department of Health 2002).

The NHS will also cover the costs of any additional equipment related to a health condition that nurses need for care in addition to the standard equipment that a nursing home provides as part of its services. Residents of care homes (residential and nursing homes) should also have access to the full range of specialist NHS support available in other care settings and at home: for instance, chiropody or physiotherapy, as well as to the full range of available community equipment services, including pressure relief mattresses, aids to mobility and communication aids.

Residential care charges

If an older person satisfies the local authority's eligibility criteria for a care home place, then a financial assessment will be carried out according to national rules for means-testing. Local authorities are not allowed to set their own savings limits for funding, as these are set nationally. These Charging for Residential Accommodation Guide (CRAG) (Department of Health 2005a) rules determine what financial contribution, if any, the local authority will make to the care home fees. In all cases of means-testing, the older person's assets and income are assessed separately from those of any partner.

The care home costs that are means-tested cover lodging and food (the so-called 'hotel costs') and personal care (that is, everything except nursing care). The exception is Scotland where, following the Royal Commission, it was decided to offer state-funded personal care to people over 65 up to the value of £145 a week in care homes.

In England, if the older person has assets (including savings, investments and the value of any home) more than a specified amount (£20,500 in 2005/6), then they must pay the full cost of the care home (except for any eligible free nursing care).

Older people often resent having to sell their house in order to fund a care home place at the end of their lives. Under the CRAG rules, the value of the home is taken into account in the financial assessment except in the following conditions:

- following the 1999 Royal Commission, it was decided that the value of a home should be disregarded for the first 12 weeks after entering a care home permanently. Around 30,000 people a year benefit from this arrangement
- if a spouse or partner still lives in the home

- if a relative aged 60 or over lives in the home
- if a relative under 60 who is incapacitated lives there
- if someone living there is responsible for a child under 16 and the house is their main home
- if someone has moved into a care home on a temporary basis (which can usually mean up to 52 weeks), then the local authority should ignore the value of the home
- the value of the home will be ignored for up to six months, sometimes longer, if the owner is trying to sell it.

The local authority cannot force someone to sell a home, even if it has the right to include the value of the home in the financial assessment. In this case, the local authority can offer a 'deferred payments arrangement' whereby the final costs must be paid back (interest free) when the home is finally sold or the estate wound up. Interest starts to be payable 56 days after either a person's death or the date the agreement is terminated. This arrangement only covers a home, so other assets and income must still be used to meet the care home fees.

Anyone with total assets of less than £20,500 (2005/6) will be assessed for both savings and income in order to determine the amount of state funding. The value of any savings is converted into a notional 'tariff income' which adds £1 to the older person's weekly income for every £250 (or part of £250) between the lower savings limit (£12,500 in 2005/6) and the upper savings limit (£20,500 in 2005/6). A person's assessed income includes this tariff income plus most other sources of income such as pension (state, occupational or personal), state benefits (including Attendance Allowance, Housing Benefit and Council Tax Benefit) and investment income. (The rules are complex, and some income is exempt.)

Generally, any income more than the 'personal expenses allowance' of £18.80 a week (2005/6) must be contributed towards the care home fees (up to the actual cost of the fees). (A local authority is allowed to provide a higher personal allowance, for example to avoid hardship or to help a partner still living at home). The local authority will then provide funding to cover the difference between the older person's assessed income (net of the personal expenses allowance) and the care home fee that has been agreed.

It is therefore slightly misleading to describe someone as receiving 'fully funded' residential care because, at the minimum, an older person will be expected to contribute all but £18.50 a week of any state pension. If someone's assets are below the lower savings limit, their income will still be assessed and anything above £18.80 a week will have to be contributed to the care home fees.

If the local authority decides that it will pay some or all of the care home costs, it will inform the person of the amount that they are willing to pay and provide details of suitable care homes in the area in this price range. The 'Direction on Choice' obliges a council to offer supported people a choice of placements at the council's 'usual price'. This Direction is a revised 1992 amendment to the 1948 National Assistance Act. The level of funding is supposed to be realistic, and if the amount is too low to pay for a suitable home then action by the recipient of care can be attempted through the local authority complaints procedure. However, as previously mentioned, it is commonplace for third parties to contribute top-up payments (Office of Fair Trading 2005) towards care home fees.

A partner's savings and income should not be taken into account when the local authority calculates how much someone should contribute to care home fee costs. However, there are separate rules which permit the local authority to approach a spouse (not unmarried partner) to ask for some payment towards the cost of the care. Ideally, this should be agreed through negotiation. If the spouse refuses, but it is very clear that they can afford to contribute, then court action can be taken.

Anyone who gives away their home or assets in order to avoid paying care home fees is guilty of 'deprivation of assets'. If the local authority believes someone has done this, then the financial assessment will assume that the person still owns the assets in question. What matters is the intention of the owner when he/she gave away the assets. There are no strict rules, but if the transfer of the assets took place within six months of entry into a care home then the local authority may try to claim the fees from the person subsequently owning the assets. Even if the divestment took place longer ago, then the local authority might still try to bill the person who gave away the assets.

Following admittance into residential care in England, an older person who is self-funding can continue to receive state benefits such as the state pension, Attendance Allowance and Pension Credit, but would normally not receive Housing Benefit or Council Tax Benefit. Any carer would normally stop receiving Carer's Allowance after four weeks.

An older person who is receiving financial help from the local authority towards care home fees will continue to receive the state pension and pension credit, but this income is then available to go towards the care home fees. In contrast with self-funders, Attendance Allowance stops after four weeks for anyone who is state supported in a care home, although if the whole of this allowance was being contributed towards the care home fees, the effect of the stoppage is simply to shift this slice of state funding out of the central government budget and into the local authority budget. Housing Benefit, Council Tax Benefit and Carer's Allowance would all normally stop.

If someone is entering a care home for what is expected to be a temporary stay then the local authority does not have to do a full means-test for the first eight weeks.

Charges for community-based care

The charging structure for non-residential social care services is set by the local authority, although there are national guidelines (Department of Health 2003) for what is acceptable. In England, means-tested charges can be imposed for almost all non-residential social care services including personal care.

There is a big variation in what is on offer. Some councils provide many services for free, some use means tests, others charge a standard rate. The Audit Commission report, *Charging with Care* (Audit Commission 2000a) described four main charging models then being operated by councils:

- a flat rate charge applied to all (but usually with an exemption for those with very low incomes)
- a charge assessed according to the level of service received, with no regard to the user's means
- a charge assessed according to the user's means, with no regard to the level of service
- a charge assessed according to both level of service and the user's means.

The council must first assess what services a person needs, and only then assess how much that person can afford to pay. If payment is not forthcoming, the services cannot be withdrawn. However, the council can take action to recover the debt.

Since 2001, in England the 'fairer charging' guidance have laid down charging principles that limit a local authority's freedom and outlines how any charging structure should relate to the main state benefits. It seeks to ensure greater consistency in charging policies. But it is a matter for councils' discretion whether to be more generous than outlined in the guidelines.

- Flat-rate charges are acceptable only in limited circumstances. The government's view is that charging models that take no account of a user's means are not acceptable.
- Anyone receiving the guarantee credit part of Pension Credit should not be charged for non-residential care. Nor should charges ever reduce an older person's net income to less than an amount 25 per cent higher than the appropriate basic guarantee credit part of Pension Credit (including any carer's premium but not the Severe Disability Premium). This sets a minimum net weekly income of about £137 (if single) and £209 (with a partner) in 2005/6, regardless of the level of services received.
- When assessing a user's savings and income in order to decide charges, as a minimum, the same CRAG savings limits as for residential care charges (Department of Health 2005a) should be applied and the same procedure used to calculate a 'tariff income'. Councils may wish to set higher savings limits or more generous charging policies for users with savings, but should not set lower limits. Thus an older person with savings above £20,500 (for 2005/6) may be required to pay the full charges for the social care services, but this will depend on the local authority.
- The exception to the CRAG rules is that the value of the home does not count when means-testing an older person for community-based social care.
- If disability benefits (for example, Attendance Allowance) are taken into account as income in assessing ability to pay a charge, councils should also assess the individual user's disability-related expenditure and this amount should be deducted from the assessed income.
- Pension Credit savings credit is ignored when calculating what charges should be made for social care.
- Earnings should be disregarded in charge assessments in order to ensure that disabled people and their carers are able to work, if they want to.
- As an additional way of ensuring that all users have adequate residual income, councils may choose to set a maximum percentage of disposable income that can be taken in charges.
- In setting the level of actual charges, councils should take account of the full cost of providing the service, excluding costs associated with running the system. Councils can decide whether to levy a contribution to costs or to seek to recover full costs, where possible.
- Councils should consider and specifically consult on the need to set a maximum charge. In some councils, this is set at a proportion of typical local residential care charges, to ensure that no perverse financial incentive is created for users to leave their own homes (that is, if a person is being charged more for non-residential services than a care home would cost, there is no incentive to remain at home rather than going into a care home).
- Councils have a responsibility to seek to maximise the incomes of users, where they would be entitled to state benefits, particularly when the user is asked to pay a charge.

Shortcomings and anomalies of the funding system

The following criticisms can be made of the current means-tested funding system. These are legitimate shortcomings but for balance it needs also to be recognised that alternative funding arrangements might also exhibit some of these shortcomings. Specific points are made in what follows in this regard.

Ignorance about the system

Too many people reach retirement without an accurate understanding of what the state will provide in terms of social care. This means that at a time of crisis, perhaps after a fall or a stroke, an older person can discover for the first time that state-funding for social care is available only to those who meet both the means-testing and needs eligibility criteria. Older people who are themselves carers are often similarly in the dark about what state-funded support may be available to them. Various government initiatives are under way to improve the provision of information to older people, including the Department of Work and Pension's development of a new welcome pack to be sent automatically to people reaching the age of 65, setting out the range of services that are available to them (Department of Trade and Industry 2005).

The health care and social care boundary

The boundary between health and social care needs is far less clear-cut in reality than the funding regime implies. In the scenario that has the most extreme financial consequences, it is sometimes very difficult to distinguish between the needs of someone receiving free NHS continuing care (including free accommodation) and someone with very high personal care needs due, for instance, to severe dementia. The latter may well receive free nursing care (under one of the three bands), but will only receive state funding towards their personal care if income and assets are below the means-testing threshold. The result can be a difference between receiving completely free NHS continuing care or ending up in residential care with a personal expenses allowance of just £18.80 a week. The Select Committee on Health (Health Committee 2005) suggested that someone eligible for the top band of free nursing care was likely to have needs of similar severity to someone in continuing health care. The committee recommended the integration of the system for funding NHS continuing care and that for funding free nursing care, but this has not been taken up by the government.

The Joseph Rowntree Foundation (Hirsch 2005) has made a number of suggestions including to merge continuing care individuals with those on the highest nursing band and consider giving everyone in this category free nursing and personal care, but consider charging everyone for accommodation and food costs. Its review also offered the idea of a 'dependency' scale which gives points for high-end personal care as well as nursing care, and which could be used to award payments in place of present nursing bands.

There is also the inconsistent treatment that results from the lack of national eligibility criteria for NHS continuing care. This means that eligibility varies between different strategic health authorities, so that the same person may or may not qualify for fully funded care depending on where they live. The government has recognised this anomaly, and has commissioned a new national framework for continuing care which should lead to greater consistency through national eligibility criteria (*see* Background Paper 2

('Continuing Care').) All of a patient's needs will be considered, including psychological and mental health limitations, which should encourage the system to consider the needs of people with, for example, dementia, on the same basis as physical needs.

Separately, the introduction of three bands of free nursing care following the Royal Commission was widely welcomed. But it has also highlighted the difficulty of drawing a line between medical care (in this case nursing care) and personal care. The relevant definition of nursing care is registered nurse time spent on providing, delegating or supervising nursing care in all settings (Department of Health 2001a). It does not include any time spent by any other staff, such as care assistants, who may also be involved in the care. But the Health Select Committee pointed out that nowadays non-nurses are doing some nursing-type work. And regardless of who performs the task, the business of delineating nursing and non-nursing tasks can sometimes be subtle. Those suffering from dementia appear to be particularly ill-served by the system as definitions of nursing care tend not to include all the care demands of someone with dementia. Under the current system, nurses also often resent being put in the position of gate-keepers to the funding regime, whereby their decisions determine whether someone receives free nursing care or means-tested personal care.

This boundary issue is an important problem, one that is particularly stark for the current means-testing system. However, any social care funding arrangement that makes a charge – even for hotel or housing aspects of the care package – will experience a boundary somewhere with a fully funded service. For instance, even a free personal care system as in Scotland can still impose hotel charges on people in care homes, and so if used here would still present an incentive for an individual to be classified for NHS continuing care.

The complexity

The complexity of the means-testing system discourages older people from pursuing state funding for which they might be eligible. This is particularly true for means-tested state benefits, and even the government itself appears to have admitted defeat regarding the comprehensive take-up of state benefits by those eligible. For instance, in estimating future costs, it currently assumes that no more than 75 per cent of those eligible will claim Pension Credit (Pensions Policy Institute 2005). A review of the take-up of means-tested benefits by British pensioners (Hancock *et al* 2004) looked at data from 1997 to 2000 and found 36 per cent of sampled pensioners failed to claim at least one benefit, and 16 per cent failed to claim amounts worth more than 10 per cent of their disposable income. All this can mean an older person has less money available to pay for social care. The intricacies of the means-testing rules for social care also mean mistakes are easy to make. Among self-paying residents in care homes, there is evidence that around 6 per cent of people were being admitted to homes as self-funders when their income and assets profile meant they were entitled to public support (Netten *et al* 2001).

The boost to income that benefits can provide has been indicated to have a beneficial impact on well-being. One piece of research has looked into the health benefits of welfare rights advice in GPs surgeries. This included a small-scale, longitudinal survey comparing the health of people whose income was increased by welfare rights advice with those whose income was not increased. There were seven sites in England, and 345 people were interviewed at 6 months and 12 months). Subjects were generally 'in the second half of

life', with one or more chronic conditions. Those who increased their income had significantly better outcomes at 12 months in mental health and emotional role functioning than those with no income increase. The study concluded that the improvements in health were only modest, but quality of life was significantly better, suggesting 'welfare benefits advice has a role to play as part of holistic care for low-income patients with chronic conditions' (Abbott *et al* 2006).

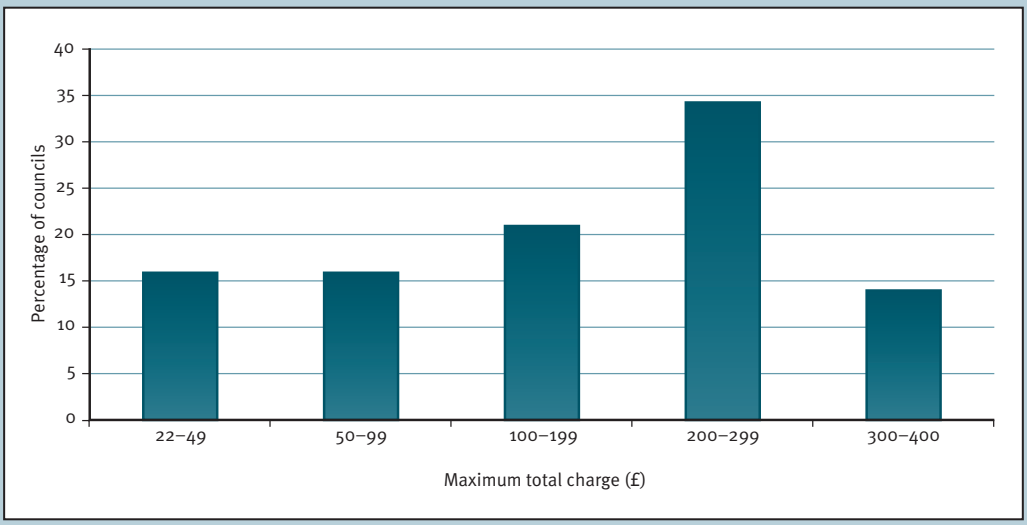
Again, because social care often works with people that would be eligible for social security benefits of one form or another, few alternative funding arrangements would completely side-step the complexity of the benefits system.

The 'post-code lottery' for domiciliary charges

The means-testing regime for residential care is governed by the national CRAG rules, but the situation for community-based care services is controlled by local authorities, both in terms of the application of the means-testing guidelines and in terms of the hourly charging price for care. This produces some stark differences in the level of overall financial contribution that will be due from an older person for the same package of social care in different local authority areas. The less 'generous' local authorities may, of course, also
be levying lower Council Tax charges, but this would be unlikely to compensate the older person contributing to social care fully. They might also be offering more care to more people.

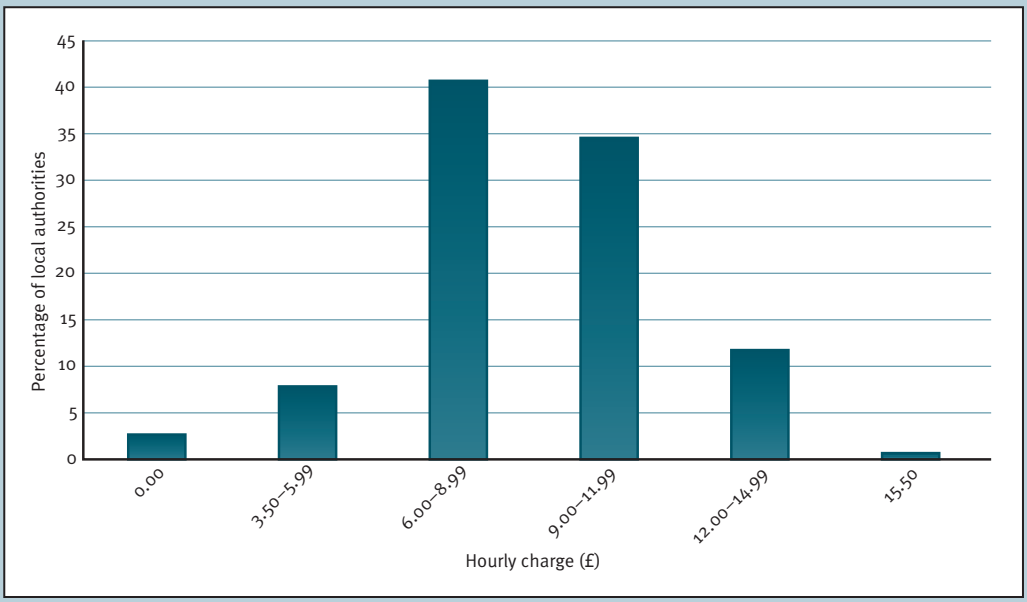
Age Concern (Thompson and Matthew 2004) conducted a survey of local authorities that demonstrated the wide variations among local authorities. Some 71 per cent of responding authorities set a maximum threshold for total charges (while others charged the full amount or used a banding system). However, among the 58 responding local authorities

1 **MAXIMUM WEEKLY CHARGE FOR COMMUNITY-BASED SOCIAL SERVICES**



Source: Thompson and Mathew 2004

2 HOURLY HOME CARE CHARGE AT 74 LOCAL AUTHORITIES



Source: Thompson and Mathew 2004

that set a maximum for charges, there was a big variation (*see* Figure 1).

There was a similarly wide variation in the hourly charge for home care set by the councils, ranging from £3.50 to £15.50, with an average of £9. Four charging systems had a higher hourly rate for people with capital and/or a high income than for other groups. Some councils had variable charges or a banding system, which meant that older people with higher levels of service needs did not pay very high charges. The variation is shown in Figure 2.

Another area of big variation is the assessment for disability-related expenditure (DRE), which is offset against total income if disability-related benefits (such as Attendance Allowance) have been taken into account in the income calculation. This can make a big difference to any final charge. In the Age Concern study (Thompson and Matthew 2004), 54 surveyed councils provided calculations that identified the amount of DRE 'awarded' to a specific case study provided to them by Age Concern. The average DRE was £34.76, but the amounts ranged from just £4.09 a week to £70.38 a week, with a similarly big impact on the final charges.

The variability between local authorities affects not only the level of charges, but also the financial assessment that determines whether a person qualifies for state-funded care at all. For instance, the Department of Health guidance on means-testing for domiciliary care permits councils to decide whether to include Attendance Allowance and other disability benefits as assessable income in the context of community-based care. In the survey, 67 councils included such allowances in full, but 15 did not include some or all of these benefits to the advantage of the older person. Similarly, councils are permitted to assess non-housing assets in line with the CRAG rules, so that an older person with non-housing assets above £20,500 (2005/6) will face full charges, but some councils ignore assets

completely when carrying out the financial assessment and others have no upper capital limit.

Savers are penalised

The means-testing system potentially penalises relatively low-income workers who accumulate relatively modest savings during their working life. This includes savings, investments and contributions to a personal pension that after retirement produces an income to supplement the state pension. Such a person might well manage to accumulate (non-housing) assets above either the upper capital limit of £20,500 (2005/6) or the lower capital limit of £12,500 (2005/6), meaning that he or she would be liable, respectively, to pay all or part of any care home fees regardless of any housing wealth. A private pension income, combined with assets, would similarly increase the likelihood of incurring charges for community-based care, where the weekly net income cut-off level for a single person is often £137 a week, above which care charges are imposed. This 'eligibility trap' is particularly resented by older people who have limited financial means, but who find themselves just outside the sharp cut-off limits for state funding.

The 'perverse incentive'

The structure of the means-testing system could in some instances encourage local authorities to promote residential care rather than community-based care. This is because an older person with significant housing wealth but low income and financial assets presents the local authority with two very distinct financial scenarios. If the older person is living alone, then the housing wealth means that a residential care place will be self-funded. Alternatively, the low-income level could result in a home-based care package that would be wholly paid for by the local authority. A cash-strapped local authority might thus be tempted to encourage the older person to opt for residential care. Taking a longer term view, the choice is more subtle as unnecessary entry into residential care will indeed erode a self-funder's assets, but once these assets erode to the upper capital limit, the local authority will have to take over paying for some (and then all) of the care home place. This could cost the local authority more in the long-term than if it had encouraged the original domiciliary care package. Conversely, if a person had low wealth the social services might end up bearing a greater net cost of someone going into a care home, where that also includes housing costs, compared to a domiciliary care placement where the housing element is supported by state benefits such as Housing Benefit and Council Tax Benefit.

Another reason a local authority's charging regime can encourage residential care was pointed out by Wright (Wright 2003). This study found that some local authorities imposed ceilings on individual community care packages. This meant that when a ceiling was low, a highly dependent older person might be under pressure to enter a care home unnecessarily unless there were savings or income available to purchase more home-based care.

Attendance Allowance

Attendance Allowance (and Disability Living Allowance for those who continue to qualify after the age of 65) are the main non-means-tested disability-related state benefits for older people. Eligibility for Attendance Allowance is governed by the need for help or supervision, but the claimant does not actually have to be in receipt of such support.

It is a compensation for disability rather than a payment to cover the costs of services, and is not taxable.

Attendance Allowance is paid at two rates, depending on whether the older person needs assistance during the day and/or night, and is not means tested. In total, these two benefits account for a large slice of state spending. In 2004/5, £3 billion was paid in Attendance Allowance in England and a further £0.7 billion[1] in DLA care component to those aged 65 and over, a total of £3.7 billion in non-means-tested funding. The Attendance Allowance funding arises from new disabilities which start after the state pension age. In February 2005, 1.14 million people were receiving Attendance Allowance in England. The majority of claimants living in the community did not report using formal community-based services (For details on Attendance Allowance recipients, see the Review, Chapter 6 ('Who pays what?')).

Attendance Allowance, in particular, often serves to boost the incomes of lower-income pensioner households. There is little evidence or research about exactly how the money is spent. Anecdotally, Attendance Allowance often provides a base level of state support for someone who needs social care, but who falls outside the means-testing threshold and who often continues to rely on informal care. But some of the money is also used by such individuals to pay for care, either formally or in the 'grey' market. It would be particularly interesting to know how much Attendance Allowance is used on services that would not be considered traditional social care, such as paying for recreation or taxis. This would allow consideration of whether this benefit is achieving the desired outcomes, although any moves to link it to the delivery of specific services could conflict with wider aims of greater choice for older people. In this sense, Attendance Allowance offers even more flexibility than a direct payment, but without the means-testing. Attendance Allowance also subsidises private funding of care home places, because self-funders in residential care continue to receive the allowance.

More broadly, there is a need for debate as to how social care related benefits such as Attendance Allowance work alongside commissioner-mediated funding (by councils and the NHS). While this benefit is very popular precisely because it can be obtained without passing through the means-testing process, its role relative to means-tested social care needs to be clarified.

Illustrative vignettes

The charges that an older person will be asked by the local authority to pay towards social care vary enormously depending on the older person's financial situation and where they live. This Review has prepared a number of very simple illustrative vignettes in order to demonstrate what the means-testing system means in practice. For domiciliary care charges, this shows the impact of different charging regimes in 'high-charging' and 'low-charging' local authority areas.

The box gives the financial profiles of four single people aged 65 and over. These four individuals are then 'assessed' for charges, firstly for a care home place under the national charging rules, and then for a domiciliary care package under a number of different local authority charging regimes. As already described, the freedom that local authorities have within the national guidelines to decide their charging rules for domiciliary care means that charges vary greatly between areas for the same care package.

EXAMPLE FINANCIAL PROFILES OF FOUR SINGLE PEOPLE AGED 65+

Person A
Net housing wealth: £100,000
Savings: £25,000
State pension: £98 a week (net)
Occupational pension: £120 a week (net)

Person B
Net housing wealth: £60,000
Savings: £12,000
State pension: £98 a week (net)
Occupational pension: £50 a week (net)

Person C
Net housing wealth: None
Savings: £25,000
State pension: £82.10 a week (net)
Occupational pension: None

Person D
Net housing wealth: None
Savings: £12,000
State pension: £82.10 a week (net)
Occupational pension: None

Care home charges

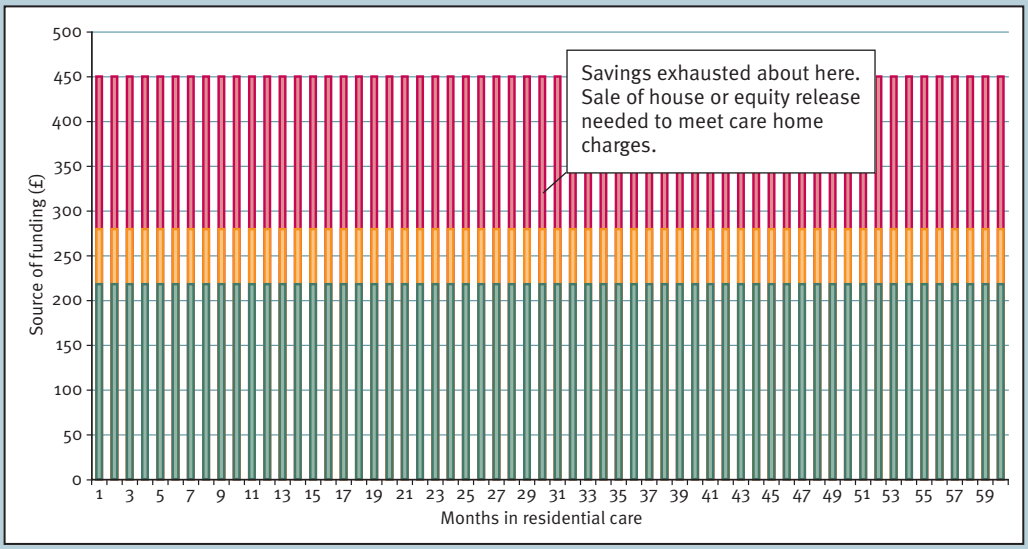
Charges towards care home fees can be levied only according to the rules set out in the CRAG (Department of Health 2005a). A time-frame of five years is used in these vignettes. In the examples below, the weekly care home fee is assumed to be £450 (not including any nursing care element). A number of assumptions[2] have been made when calculating the charges. Three are particularly important. Firstly, all Pension Credit and CRAG calculations are (unrealistically) re-done every month so that a self-funder immediately benefits from any erosion of assets. Secondly, self-funders only allow themselves £18.80 a week of personal spending money, in line with the amount given to state-funded residents. In doing the calculations, a self-funder is assumed to take that weekly allowance out of savings, whereas anyone who is state funded keeps £18.80 of his/her pension income. Thirdly, the two individuals with housing assets (Person A and Person B) do not sell their homes immediately on moving into a care home; this is either because they do not want to, or because someone else remains living in the property but that person is not in one of the categories (for example, an incapacitated relative under the age of 60) that removes the house from the means-testing assessment. (If the older person did sell the house immediately and put the proceeds in the bank, they would begin to draw on these savings at the point where they sell the house in the charts below).

The four charts show the source of the money that pays the weekly care home fees for each of the four case study individuals.

- It can be seen in Figure 3 that Person A never qualifies for state funding under the five-year horizon. After about 30 months the user's savings are exhausted and it is necessary to sell the home or use equity release to meet the care home fees.
- Figure 4 shows how Person B receives some state funding in the first 12 weeks, when the value of the house is disregarded. After that the user is fully self-funding, and is forced to sell the home after about 14 months in total (the net value of the house is

3 **PERSON A: FUNDING SOURCES FOR SELF-FUNDER ADMITTED TO RESIDENTIAL CARE COSTING £450 PER WEEK, WITH £18.80 PER WEEK PERSONAL EXPENDITURE OR ALLOWANCE**

Net housing wealth: £100,000 Savings: £25,000 State pension: £98 per week (net)
Occupational pension: £120 per week (net)



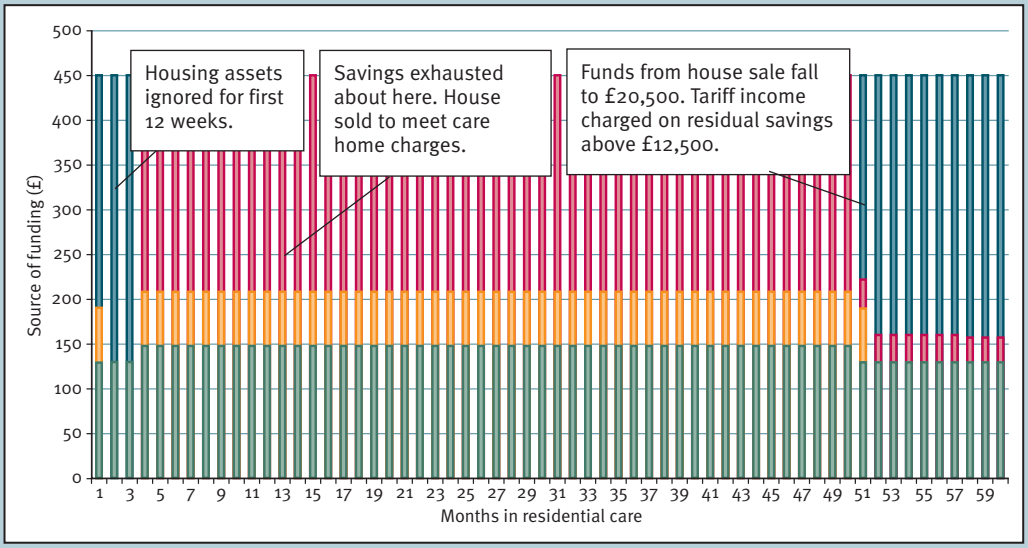
KEY

- Pension income: state and occupational combined
- Attendance Allowance
- Private assets

Source: Figures produced using software from Ferret Information Systems

4 **PERSON B: FUNDING SOURCES FOR CARE HOME PLACE COSTING £450 PER WEEK, WITH £18.80 PER WEEK PERSONAL EXPENDITURE OR ALLOWANCE**

Net housing wealth: £60,000 Savings: £12,000 State pension: £98 per week (net)
Occupational pension: £50 per week (net)



KEY

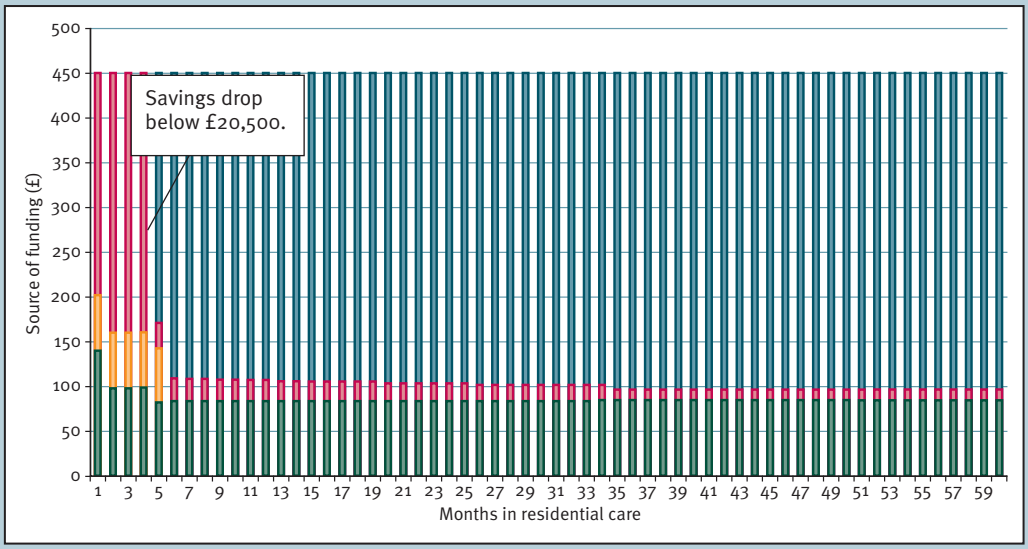
- Pension income: state and occupational combined
- Attendance Allowance
- Private assets
- Local authority contribution

Source: Figures produced using software from Ferret Information Systems

probably too low for equity release). It is not until after 52 months that this person's assets are eroded to the upper threshold (£20,500 in 2005/6), and the local authority starts to contribute. This point represents the 'cliff-edge' of the means-testing system, as a person's contribution to care home fees falls sharply when assets erode to the upper threshold. After this point, the tariff income is charged on the total value of the assets between £12,500 and £20,500, so this tariff income also declines gradually as the assets are further eroded.

5 **PERSON C: FUNDING SOURCES FOR CARE HOME PLACE COSTING £450 PER WEEK, WITH £18.80 PER WEEK PERSONAL EXPENDITURE OR ALLOWANCE**

Net housing wealth: None Savings: £25,000 State pension: £82.10 per week (net) Occupational pension: None



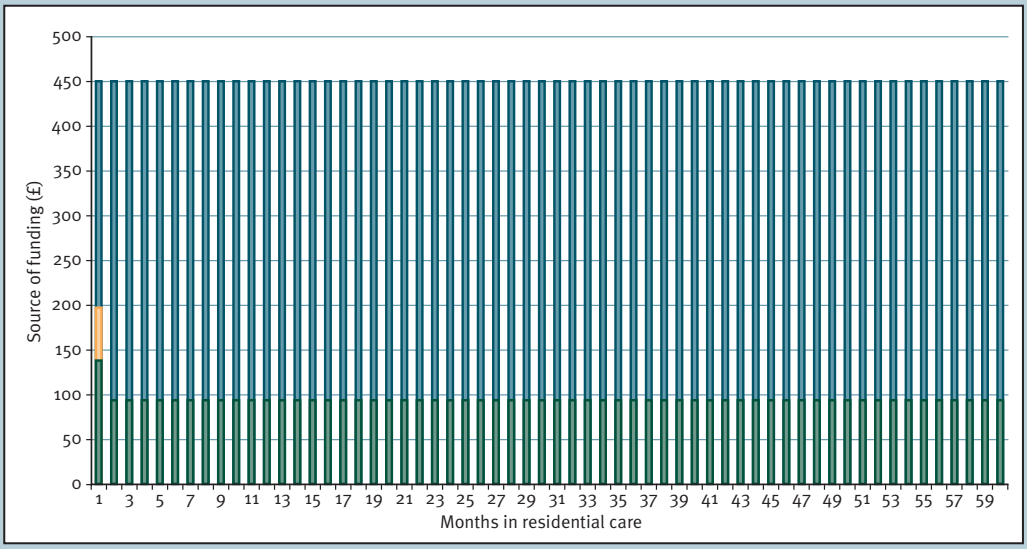
KEY

- Pension income: state pension and pension credit
- Attendance Allowance
- Private assets
- Local authority contribution

Source: Figures produced using software from Ferret Information Systems

6 **PERSON D: FUNDING SOURCES FOR CARE HOME PLACE COSTING £450 PER WEEK, WITH £18.80 PER WEEK PERSONAL ALLOWANCE**

Net housing wealth: None Savings: £12,000 State pension: £82.10 per week (net) Occupational pension: None



KEY

- Pension income: state pension and pension credit
- Attendance Allowance
- Local authority contribution

Source: Figures produced using software from Ferret Information Systems

- Person C very quickly erodes their savings down to £20,500 and from month 5 onwards is significantly funded by the local authority. As with Person B, the tariff income then becomes relevant. Figure 5 shows clearly how long it takes for that tariff 'tail' to diminish, as the resulting contribution is always less than £32 a week.
- Person D's financial circumstances are such that from the start they are wholly state-funded (Figure 6), although as usual this involves parting with all pension income except for the £18.80 personal allowance.

Domiciliary care charges

The picture for domiciliary care charges is rather more complex because of the freedom that local authorities have to design charging regimes with the Fairer Charging guidelines. In this case the vignettes have used actual charging rules as operated in mid-2005 by two local authorities (they are not identified here) in England to calculate the weekly charge that would be imposed at the start of a care home package, based on various assumptions.[3] One was a low-charging council and one was a high-charging council when compared with the average. It turned out that neither of these two councils took an older person's (non-housing) assets into account when assessing a user for charges. Under the national guidelines, a council can assess (non-housing) assets as under the CRAG rules if it chooses, but it can be more generous. In order to demonstrate the impact of ignoring (non-housing) assets, a second set of estimates was done on the assumption that each of the two councils kept the same charging rules but also assessed for assets. These figures are all given in Table 8.

The table illustrates the reality of the 'postcode lottery'. It can be seen that the decision to ignore assets has a big impact on Person A and Person C if they live in the high-charging local authority, and a lesser impact on Person C in the low-charging area. This suggests that if councils charged the maximum permitted under the guidelines, significantly more

TABLE 8: WEEKLY CHARGES DUE FROM USER FOR DOMICILIARY CARE PACKAGE

	Weekly charges			
	Person A	**Person B**	**Person C**	**Person D**
Low-charging council (ignores assets)	£33.88	£33.88	£0	£0
Low-charging council (assesses assets)	£33.88	£33.88	£33.88 (After 133 weeks this drops to £0.)	£0
High-charging council (ignores assets)	£87.32	£32.22	£0	£0
High-charging council (assesses assets)	£147.00 (After 31 weeks this drops to £119.32. It then declines by about £2.00 a month down to £87.32.)	£32.22	£147.00 (After 31 weeks this drops to £0.)	£0

Source: Figures produced using software from Ferret Information Systems

money could be recouped in charges. If assets are assessed, Person A and Person C are much better off if they move to the low-charging council area. If assets are ignored, Person A is also well-advised to move into the low charging council's area, as this will still save more than £50 a week in charges.

The table also gives some indication of how the charges will evolve over time as a user's assets are eroded. As housing assets are never assessed for domiciliary care, this has less severe consequences than when paying care home fees.

Social attitudes to paying and inheritance

Attitudes to self-funding social care are difficult to assess and often inconsistent. A survey carried out in 1995 (Parker and Clarke 1997) found that public opinion was divided. Some 24 per cent of respondents supported state support for all, regardless of income, while 24 per cent supported a means-tested approach, with the state providing for only those who could not otherwise afford care. The most popular option, chosen by 48 per cent of respondents, was for the state to provide a basic level of service for older people, with the option open to people who could afford to do so of 'topping up' or supplementing this basic service.

A more recent survey carried out in the wake of the Royal Commission report asked people aged over 25 about whether the state or individuals should pay for long-term care costs of the elderly (Deeming 2001). More than three out of five people believed that personal care should be provided free to all who needed it, regardless of whether care was provided in hospital, in care homes or in people's own homes. Stronger support for universal free personal care for all was found among younger voters (25–44 years) – precisely those people whom government wants to encourage to save for their old age. On personal care in nursing homes, only one in ten thought it reasonable to pay the full cost of personal care; six out of ten people thought it unreasonable to pay anything at all. On personal care in one's own home, only two in ten thought it reasonable to pay for the full cost of personal care; and five out of ten people thought it unreasonable to pay anything at all.

A subsequent analysis (Deeming and Keen 2003) found a significant majority (61 per cent) were in favour of collective public financing of comprehensive health and social care services, 26 per cent supported a top-up model of finance and 12 per cent supported a means-tested system of finance. Comparisons between income groups found that support for means-testing was significantly higher among those earning £199 or less per week compared with all other income groups; support was also significantly higher among those earning £200 to £399 compared with those earning £400 to £599 per week. Overall, there was limited support for redistribution *within* the group of people who need long-term care, and the majority of people expected at least some contribution from the state. However, the 40 per cent overall who favoured at least some contribution by individuals did prefer to maximise progressive financing *within* the population of people who need long-term care – as distinct from believing that redistribution might be from tax-payers in general to people in receipt of long-term care.

Interviews with actual self-funding residents of care homes found some conflicting emotions (Wright 2003). There was an acceptance that savings were being used up, and in some cases paying privately for care was actually important for the older person's self-image. Many of the residents interviewed were insistent that meeting care home costs was the right thing to do. One 91-year-old is quoted as saying: 'Yes you should pay for yourself.

People should not suck blood from the state'. Another of 89 years agreed: 'I think it's just; it's a just thing to pay for your own care'. However, there was considerable concern about what would happen to someone who outlived their savings, including fears about eviction if the local authority would not meet the care home fees.

Many older people do resent the idea of using up savings which had been planned as an inheritance for children and other relatives. But there is some evidence that the desire to leave a bequest is not felt as strongly among those approaching retirement as it is among the current older population. A recent empirical study (Rowlingson and McKay 2005) questioned a representative sample of 2,000 people about attitudes to inheritance. The responses showed that most of those with assets were willing to use up savings and access housing equity if they needed to do so to maintain a reasonable standard of living. The report highlighted people's willingness to draw down assets as part of the normal course of managing resources throughout their lifetime, using accumulated wealth to meet current needs. It coined the acronym 'OWLS' – 'Older People Withdrawing Loot Sensibly' – to describe this phenomenon.

The survey found that two-thirds of those with some potential to leave a bequest in the future said that they would enjoy life and not worry too much about what was left. Just over a quarter said that they would be careful with their money so that they could leave something. Attitudes differed across groups.

- People in their 50s were least supportive of passing on assets rather than using them for themselves. The very old and the relatively young were both more supportive. However, even among the over-80s, a majority said they would enjoy life rather than worry about inheritance. The survey found that owner-occupiers did not see their homes primarily as potential bequests but those aged 70 or more were more likely to do so than other owner-occupiers.
- There were only relatively minor differences by social class. Only in the lowest socio-economic group were people with assets significantly more likely to want to bequeath them than average. But even among this group, a majority (54 per cent) say they would use them to enjoy life.
- Some minority-ethnic groups put much greater emphasis on inheritance than average. Nearly two-thirds (64 per cent) of Asian people and over half (57 per cent) of Black people with potential to make bequests said they would be careful with their money for this purpose.

The survey found concern among older people (aged 65 and over) that the level of the state pension was not high and payments for long-term care might use up savings later on. Generally, it was not clear whether the baby-boomers' apparent willingness to erode their children's inheritance in pursuit of an enjoyable lifestyle would extend to being content to use assets to pay care home fees and social care costs in 20 years' time. Indeed, a willingness to spend assets in their 'early old age' might instead mean that they would be more likely to qualify for state-funded care at a later date.

In a separate investigation of attitudes to paying for care, six focus groups involving people in three age categories (44–59, 60–74 and 75+) and a mix of socio-economic groups were held in the North West and South East of England (Age Concern England forthcoming). Research participants understood the distinction between health care and social care but felt it to be artificial and irrelevant to the welfare of the person in receipt of services. The

focus groups started from the premise that the state should pay for all care that was essential to maintenance of life, for example, washing, toileting, getting in and out of bed, help with medication and feeding. It was felt that older people had no choice over whether they had such care as they simply could not continue to live without it.

Participants justified this view on the grounds that people had worked all their lives and paid tax and national insurance (or in the case of some older women in the past their husbands have paid). Those in the south, where most participants were homeowners, were largely adamant that care costs were the responsibility of the state and that it was up to the government to re-think its priorities to achieve this. Most participants had children and had always anticipated that they would be able to leave their property to their children. They deemed it unfair that the value of the property that they had saved to pay for when younger should be used to fund care charges. This view extended to other financial assets as well. Interestingly, many of those in the north were more pragmatic in their appreciation of the impact of the changing demographic profile in the country.

Throughout, both north and south, the younger people (44–59) were the most convinced that the state should pay for personal care for all. The two older groups in the north, and the oldest group in the south, were more willing to consider at least a contribution to care costs. In the north, there was more support for setting a percentage of capital which should be payable towards the costs of care, but participants could not decide what that percentage might be. One suggestion was that the percentage should be on the remaining value above a certain threshold, but it was difficult to decide on the threshold level.

There was widespread confusion among participants concerning the basis for charging for personal care services, including among those currently paying for such services. The existing charging situation was felt to discriminate against those who had saved in order to provide for themselves, but who would lose these savings in payment for services which would be provided free of charge to others who had not saved. In the south, the use of private pensions, which participants felt they had paid into as a form of saving over many years, was greatly resented by many.

Participants in all groups generally agreed that items of expenditure over which a person had some choice should be met by that person whatever their financial situation, even where these contribute very significantly to the person's quality of life. These included items such as transport (taxis) and services which might relieve a condition. Similarly, there was an expectation that an individual would pay for the 'hotel' costs of a care home, where their means allowed.

Financial health of older people

A willingness to contribute to the costs of long-term care is only relevant if there is money available to spend. One study (Deeming and Keen 2002) looked at a small survey of middle- to lower-income individuals, half of whom were in their 70s and half in their 50s. The study concluded that it was unrealistic to expect people in the lower half of income distribution to be able to save for old age and long-term care. Those who struggled most were the middle-income individuals, who were not covered by the state because of means-testing, but whose assets and/or income were inadequate for funding long-term care. Overall, among those already above the pension age, many could not afford to pay for domiciliary help and had to rely on unpaid informal help. The average expenditure on health and personal goods and services was just £4 a week. For those in their 50s, half thought that when they retired they would be unable to afford to pay £2.50 a week on health and personal goods and services, and nobody thought they could afford £20 a week.

National survey data demonstrates that inequality in wealth across the older population is more extreme than inequality in incomes. In both cases, figures for 'averages' are heavily influenced by a small proportion of well-off individuals, and are of limited use when assessing the population's ability to afford social care or the likelihood of securing state-funded care. For instance, for the population over 50, the average net financial wealth (this does not include housing) is more than £40,000, but half this cohort has less than £12,000 and a quarter has less than £1,500 (Banks *et al* 2004).

Inequalities in income and wealth exist both within specified age groups (cohorts) and between different age groups. However, changes in society, such as the increased participation of women in the workforce, mean that when the baby-boomers reach the age of likely dependency (late 70s and 80+), their income and wealth profiles may well be quite different from those of present day pensioners. In particular, the rise in home ownership and the surge in property values will create an increasing divide between those who own property and those who do not. It is therefore important to look at the variation of income and wealth for the different age cohorts, including those who have not yet reached retirement.

Most useful for this Review is the data from ELSA, which provides detailed financial information on the cohort that will be moving into and through retirement over the next 20 years. It also provides a basis for comparing the existing means-testing rules with the income and assets of those most likely to need long-term care in future. In the data below, the income and assets of various cohorts of people are considered, with particular emphasis on a person's ADL status. ADL limitations start relatively early in life for a significant number of people. Some 12.6 per cent of those aged 50–59 reported difficulty with one or more ADL. That figure varies between different occupational classes with 7.7

per cent of managerial and professional people reporting one or more ADL difficulties, 9.8 per cent in intermediate occupations, 17.8 per cent in routine and manual jobs, and 18.4 per cent classified as 'other'. Thus, well before the state retirement age, those already showing indications of being at risk of needing long-term care in old age are more likely to be in lower-paying jobs (Banks *et al* 2004). The figures below show that by late middle age, a person with one or more ADL limitations is likely to have a lower income and fewer assets. (Balancing this, further into the future, are the very old, older people, who experience a relatively quick decline.)

Incomes of the 50+ population

ELSA (Banks *et al* 2004) illustrates how women tend to have lower incomes than single men, but the disparity is less for the 50–54 age band (Table 9).

TABLE 9: TOTAL WEEKLY FAMILY INCOME, BY AGE AND MARITAL STATUS (UNEQUIVALISED*)

Age band	Weekly family income		
	Single men	Single women	Couples
50–54	£236	£231	£522
55–59	£252	£195	£486
60–64	£242	£195	£436
65–69	£193	£186	£368
70–74	£188	£156	£321
75–79	£168	£147	£290
80+	£170	£156	£282

Source: Elsa 2002 data (Banks *et al* 2004)
* 'Unequivalised' means that no adjustment has been made for whether the family unit contains more than one person. (Income is net of taxes and includes employment income, private pension income, benefit income (excluding housing benefit and council tax benefit), asset income and any other measure.)

More relevantly for social care issues, ELSA provides figures for income by age and self-reported health (Table 10) which demonstrate how poor health is correlated with lower incomes. These average income figures for single men and single women in 'fair/poor' health are low enough that after allowable expenses there would be little or nothing to contribute towards means-tested home-based social care. Thus those who are likely to need domiciliary social care are also those who are least likely to be able to fund it themselves (unless they have significant non-housing wealth). Nor would such incomes be able to cover more than a proportion of residential care home costs.

The average proportion of income of those in 'fair/poor' self-reported health which is provided by the state pension and state benefits (excluding housing benefit and council

TABLE 10: TOTAL WEEKLY FAMILY INCOME, BY AGE AND SELF-REPORTED HEALTH STATUS (UNEQUIVALISED*)

Age band	Self-reported health status	Single men	Single women	Man in a couple	Woman in a couple
50–59	Excellent/very good	£295	£278	£583	£541
	Good	£257	£178	£503	£477
	Fair/poor	£162	£173	£381	£360
60–74	Excellent/very good	£259	£196	£423	£414
	Good	£193	£173	£387	£334
	Fair/poor	£166	£154	£351	£337
75+	Excellent/very good	£181	£138	£318	£315
	Good	£168	£182	£292	£287
	Fair/poor	£159	£141	£268	£255

Source: Based on ELSA 2002 data (Banks *et al* 2004)
* 'Unequivalised' means that no adjustment has been made for whether the family unit contains more than one person. (Income is net of taxes and includes employment income, private pension income, state pension income, benefit income (excluding housing benefit and council tax benefit), asset income and any other measure.)

tax benefit) is shown in Table 11. These sources of income are included in the social care means-testing financial assessment and therefore can end up being used to pay for social care, but which are not included in the local authority social care expenditure figures. The complex interaction between the means-testing regimes and state benefits is one of the challenges of estimating the total cost of social care.

TABLE 11: AVERAGE PROPORTION OF TOTAL WEEKLY FAMILY INCOME PROVIDED BY THE STATE PENSION AND STATE BENEFITS (UNEQUIVALISED*)

Age band	Self-reported health status	Single men		Single women		Man in a couple		Woman in a couple	
		% from state pension	% from state benefits	% from state pension	% from state benefits	% from state pension	% from state benefits	% from state pension	% from state benefits
50–59	Fair/poor	0	46	2	42	2	19	2	19
60–74	Fair/poor	35	28	57	19	27	21	34	19
75+	Fair/poor	57	11	62	19	52	10	57	12

Source: Calculated using Elsa 2002 data (Banks *et al* 2004)
* 'Unequivalised' means that no adjustment has been made for whether the family unit contains more than one person. (Income is net of taxes and includes employment income, private pension income, benefit income (excluding housing benefit and council tax benefit), asset income and any other measure.)

Predicted retirement incomes

It is total financial resources after retirement that is most relevant when considering whether the baby-boomer cohort will be capable of paying for long-term social care in later life. The Institute for Fiscal Studies prepared some figures for this Review, which looked at predicted retirement incomes, based on ELSA data. This work covers people aged between 50 and the State Pension Age (SPA). Based on people's income sources and assets it sets out what regular stream of income individuals could realise consistently into the future after reaching their state pension age (SPA). In particular, this total income includes future pension income, either as a defined benefit or as an annuitised defined contribution. Other non-pension, non-housing wealth is annuitised at 5 per cent to produce an income. When housing wealth is included, this is done on the basis that 50 per cent of the home's value is annuitised at 5 per cent. In the case of couples, the total joint income is assumed to be split 50:50. (The full assumptions are given in the Annex on page 49.)

The data was considered in several ways.

- Where the data is adequate, there is a three-way split: no ADL limitations, 1 ADL limitation, and 2+ ADL limitations.
- Otherwise, there is a two-way split: no ADL limitations, 1+ ADL limitations.
- Individuals were also categorised as either living alone or living with others.

The trends are clear. A person's predicted retirement income declines as the number of ADL limitations increases. Table 12 includes pension and non-housing wealth, and under the current means-testing rules would be relevant in the case of someone needing domiciliary care who did not release any housing equity. Table 13 also includes housing wealth (and expected inheritance), and so is more relevant for someone releasing housing equity to fund either domiciliary care or care home fees. It can be seen in both cases that more than half of those with one or more ADL limitations in this age cohort would not have to contribute to any long-term care costs (domiciliary or residential) under the current means-testing rules. The figures for predicted income based on total wealth can be put in a social care context by considering the likely cost of a care home place. The current annual cost of a care home placement is just under £20,000 (at £370 per week, but £450 used above). The source data shows that only about 30 per cent of fit people, 20 per cent of people with 1 ADL and 10 per cent of people with 2 ADLs could afford this amount (that

TABLE 12: DISTRIBUTION OF PREDICTED RETIREMENT INCOME (PENSION AND NON-HOUSING WEALTH)* AT STATE PENSION AGE (SPA) FOR THOSE CURRENTLY AGED 50 TO SPA, BY ADL LIMITATION

Level of dependency	Distribution of income		
	25th percentile	Median	75th percentile
No ADL limitations	£7,150	£11,350	£17,900
1 ADL limitation	£6,700	£10,000	£15,900
2+ ADL limitations	£5,350	£8,000	£12,400

Source: Prepared for this Review by the Institute for Fiscal Studies using ELSA 2002 data
* The wealth of couples is split 50:50.

TABLE 13: DISTRIBUTION OF PREDICTED RETIREMENT INCOME (TOTAL WEALTH[1])[2] AT STATE PENSION AGE (SPA) FOR THOSE CURRENTLY AGED 50 TO SPA, BY ADL LIMITATION

Level of dependency	Distribution of income		
	25th percentile	Median	75th percentile
No ADL limitations	£8,800	£13,650	£20,900
1 ADL limitation	£8,050	£11,800	£18,550
2+ ADL limitations	£6,150	£9,550	£14,750

Source: Prepared for this Review by the Institute for Fiscal Studies using ELSA 2002 data
[1] Total wealth includes housing and expected inheritance.
[2] The wealth of couples is split 50:50.

is, as above, where it is assumed that half the value of any house is taken into consideration and annuitised). (These figures do not take into account the receipt of Attendance Allowance.)

The distinction between whether someone is living alone or with others also results in a gap in predicted retirement income. In this case, the data was not adequate to provide the same three-way split in terms of ADL limitations, so a two-way split was used instead. Once again the projected incomes are given based on pension and non-housing wealth (Table 14) and total wealth (Table 15, *see* overleaf). It can be seen that in most cases, on average a person is better off when living with others. The exception is for those of higher total wealth with no ADL limitations, in which case the wealthiest 25 per cent in each group has a higher predicted retirement income if living alone.

TABLE 14: DISTRIBUTION OF PREDICTED RETIREMENT INCOME (PENSION AND NON-HOUSING WEALTH)* AT STATE PENSION AGE (SPA) FOR THOSE CURRENTLY AGED 50 TO SPA, BY ADL LIMITATION AND LIVING ARRANGEMENT

Level of dependency	Distribution of income					
	Living alone			Living with others		
	25th percentile	Median	75th percentile	25th percentile	Median	75th percentile
No ADL limitations	£6,600	£10,550	£18,150	£7,300	£11,500	£17,850
1+ ADL limitations	£4,500	£7,100	£12,400	£6,050	£9,200	£13,850

Source: Prepared for this Review by the Institute for Fiscal Studies using ELSA 2002 data
* The wealth of couples is split 50:50.

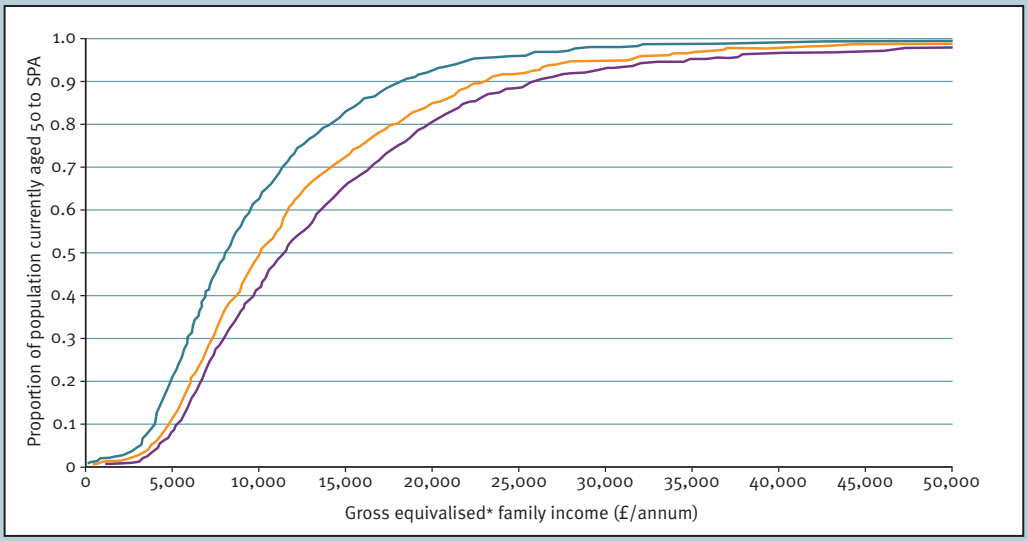
TABLE 15: DISTRIBUTION OF PREDICTED RETIREMENT INCOME (TOTAL WEALTH[1])[2] AT STATE PENSION AGE (SPA) FOR THOSE CURRENTLY AGED 50 TO SPA, BY ADL LIMITATION AND LIVING ARRANGEMENT

Level of dependency	Distribution of income					
	Living alone			Living with others		
	25th percentile	Median	75th percentile	25th percentile	Median	75th percentile
No ADL limitations	£7,950	£13,150	£21,850	£8,900	£13,800	£20,800
1+ ADL limitations	£5,400	£8,350	£14,500	£7,350	£10,750	£16,150

Source: Prepared for this Review by the Institute for Fiscal Studies using ELSA 2002 data
[1] Total wealth includes housing and expected inheritance.
[2] The wealth of couples is split 50:50.

This information is also presented in chart form in Figures 7, 8, 9 and 10, which show the cumulative proportion of the population (aged 50 to SPA) with a certain level of predicted income. The steeper the line on the graph, the higher is the proportion of individuals on a lower predicted retirement income. Figures 7 and 8 clearly show the impact of any ADL limitations on predicted retirement income, whether or not that includes housing wealth.

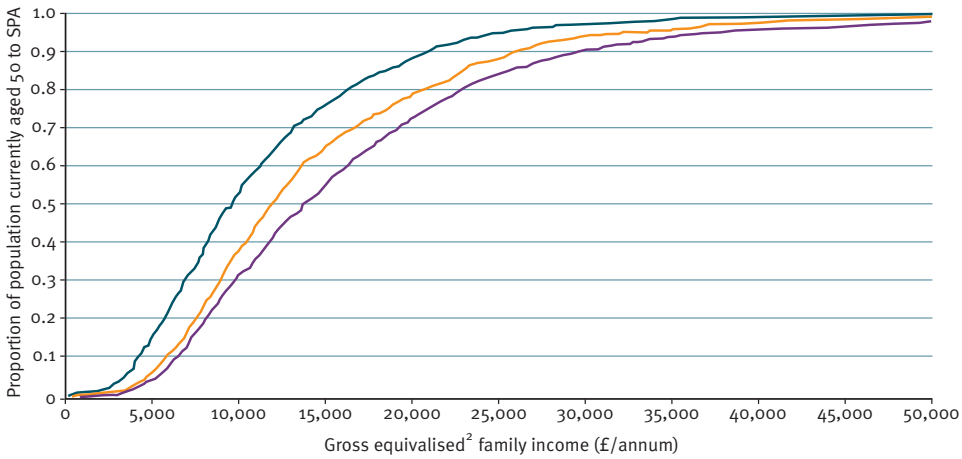
7 DISTRIBUTION OF PREDICTED RETIREMENT INCOME (PENSION AND NON-HOUSING WEALTH ONLY)* AT STATE PENSION AGE (SPA) FOR THOSE CURRENTLY AGED 50 TO SPA, BY ADL LIMITATION



KEY
- No ADL limitations
- 1 ADL limitation
- 2+ ADL limitations

Source: Figures prepared using ELSA 2002 data by the Institute for Fiscal Studies for this Review
* The wealth of couples is split 50:50.

8 DISTRIBUTION OF PREDICTED RETIREMENT INCOME (TOTAL WEALTH[1])[2] AT STATE PENSION AGE (SPA) FOR THOSE CURRENTLY AGED 50 TO SPA, BY ADL LIMITATION



KEY

- No ADL limitations
- 1 ADL limitation
- 2+ ADL limitations

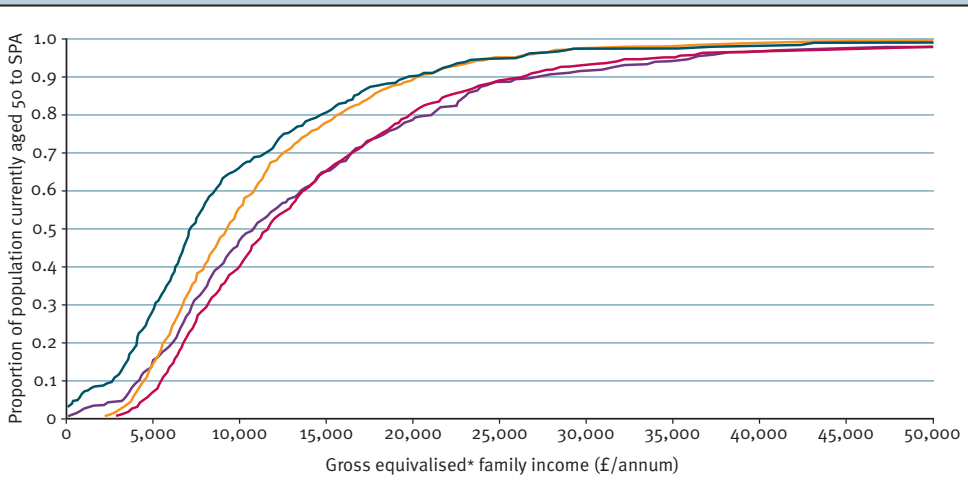
Source: Figures prepared using ELSA 2002 data by the Institute for Fiscal Studies for this Review

[1] Total wealth includes housing and expected inheritance.

[2] The wealth of couples is split 50:50.

Figures 9 and 10 similarly demonstrate how predicted retirement income is affected by living situation as well as ADL limitations. For those people with 1+ ADL limitations, living alone is associated with lower predicted retirement incomes than for people living with others. This is true regardless of whether or not housing wealth (and expected inheritance) is included. There is a similar pattern for around 60 per cent of those with no ADL limitations, but it is not as pronounced, and it is no longer the case at higher predicted incomes, as mentioned earlier.

9 DISTRIBUTION OF PREDICTED RETIREMENT INCOME (PENSION AND NON-HOUSING WEALTH ONLY)* AT STATE PENSION AGE (SPA) FOR THOSE CURRENTLY AGED 50 TO SPA, BY ADL LIMITATION AND LIVING ARRANGEMENT



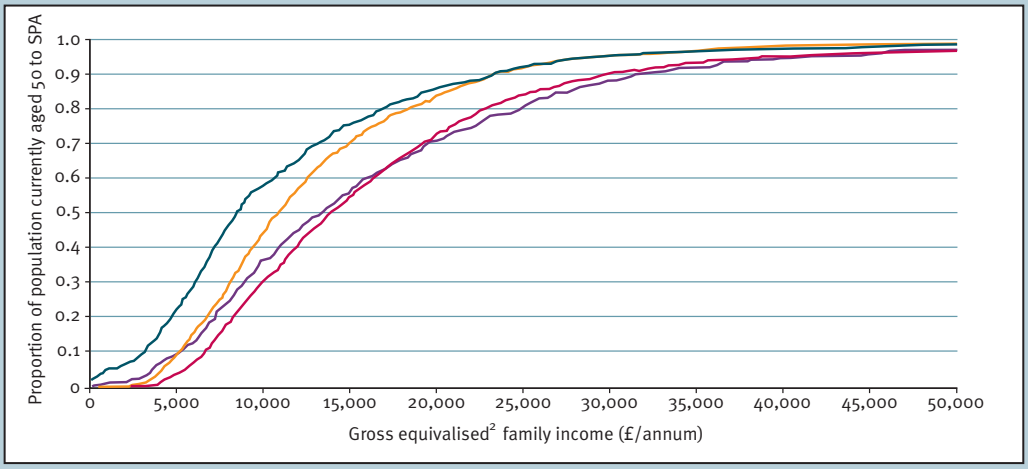
KEY

- No ADL limitations, living alone
- No ADL limitations, living with others
- 1+ ADL limitations, living alone
- 1+ ADL limitations, living with others

Source: Figures prepared using ELSA 2002 data by the Institute for Fiscal Studies for this Review

* The wealth of couples is split 50:50.

10 **DISTRIBUTION OF PREDICTED RETIREMENT INCOME (TOTAL WEALTH[1])[2] AT STATE PENSION AGE (SPA) FOR THOSE CURRENTLY AGED 50 TO SPA, BY ADL LIMITATION AND LIVING ARRANGEMENT**



KEY

- No ADL limitations, living alone
- No ADL limitations, living with others
- 1+ ADL limitations, living alone
- 1+ ADL limitations, living with others

Source: Figures prepared using ELSA 2002 data by the Institute for Fiscal Studies for this Review

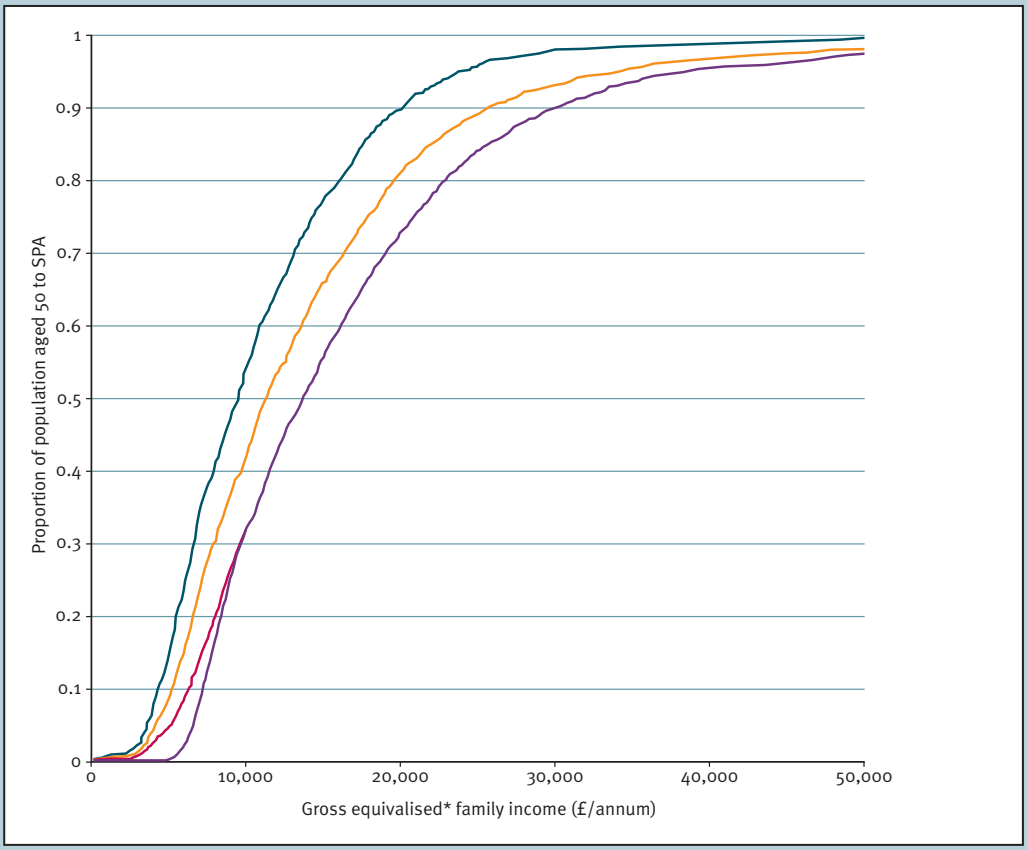
[1] Total wealth includes housing and expected inheritance.

[2] The wealth of couples is split 50:50.

A more detailed analysis was also provided by the IFS, based on ELSA 2002 data, whereby four rather than two categories of wealth were considered. Thus there were income predictions based on a) only pensions, b) pensions plus non-housing wealth, c) total wealth including housing and expected inheritance, and d) total wealth plus Pension Credit. The Pension Credit provides a minimum income below which no one should fall. For these graphs, the source data only permitted a split between individuals with no ADL limitations and those with 1+ ADL limitations. This split was then applied to a) all individuals, b) individuals living alone and c) individuals living with others.

Once again, the steeper the lines on the graphs (*see* Figures 11, 12, 13, 14, 15 and 16, pp 37–42), the higher the proportion of individuals with a lower total retirement income. In each case, the predicted retirement incomes are clearly steeper for those with 1+ ADL limitations. Pension wealth is the most important contributor to predicted retirement income for all but the wealthiest individuals. It is also evident that Pension Credit is particularly important for individuals living alone with 1+ ADL limitations.

11 DISTRIBUTION OF PREDICTED RETIREMENT INCOME AT STATE PENSION AGE (SPA) AMONG INDIVIDUALS WITH NO ADL LIMITATIONS



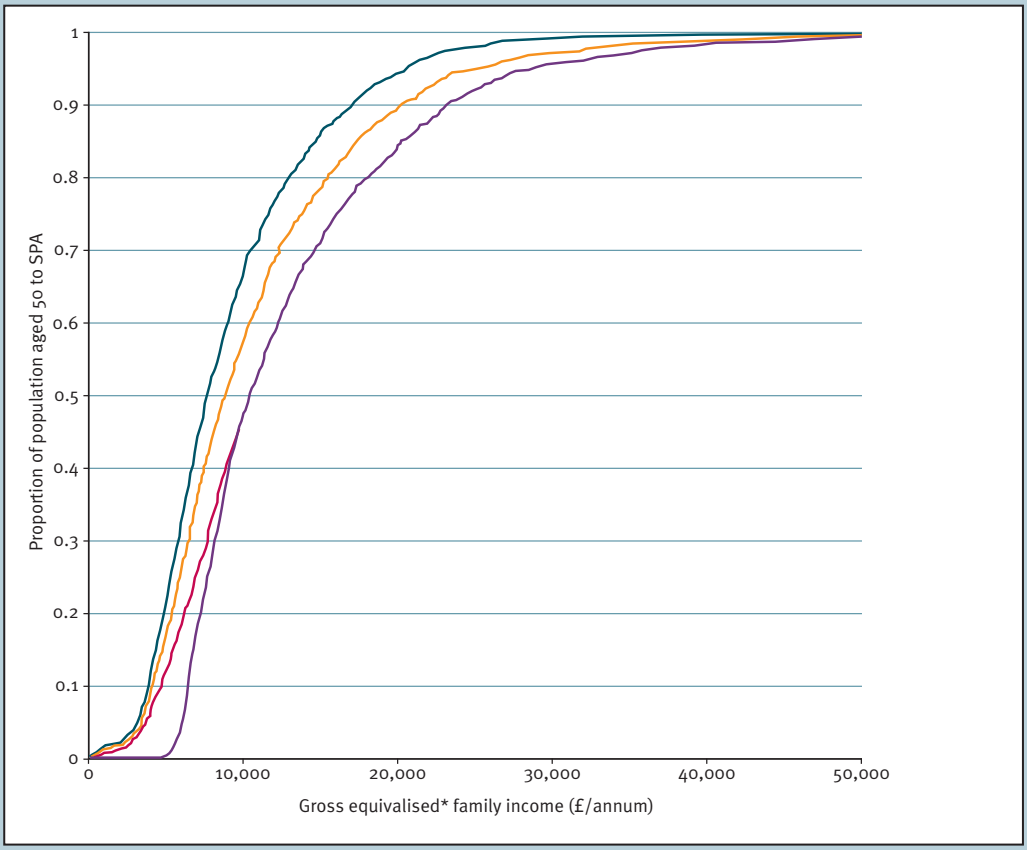
KEY

- Pension wealth
- Non-housing wealth
- Total wealth (including expected inheritance)
- Total wealth plus Pension Credit

Source: Figures prepared using ELSA 2002 data by the Institute for Fiscal Studies for this Review

* The wealth of couples is split 50:50.

12 DISTRIBUTION OF PREDICTED RETIREMENT INCOME AT STATE PENSION AGE (SPA) AMONG INDIVIDUALS WITH 1+ ADL LIMITATIONS



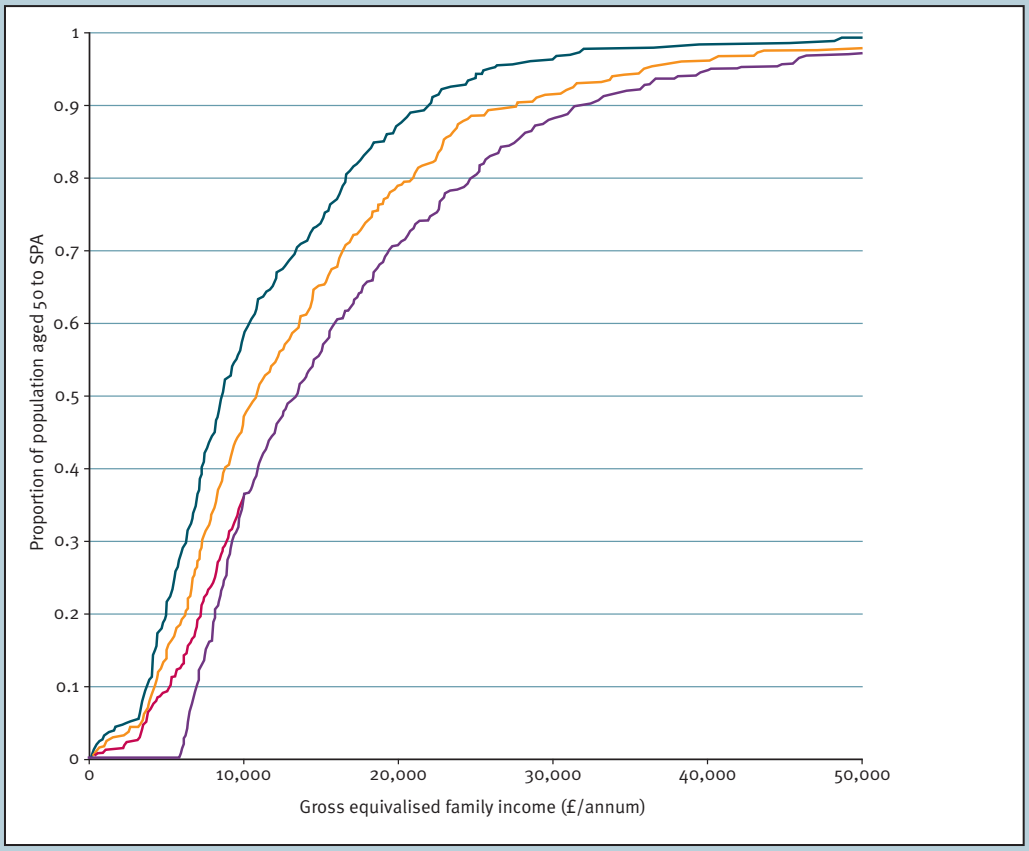
KEY

- Pension wealth
- Non-housing wealth
- Total wealth (including expected inheritance)
- Total wealth plus Pension Credit

Source: Figures prepared using ELSA 2002 data by the Institute for Fiscal Studies for this Review

* The wealth of couples is split 50:50.

13 DISTRIBUTION OF PREDICTED RETIREMENT INCOME AT STATE PENSION AGE (SPA) AMONG INDIVIDUALS LIVING ALONE WHO HAVE NO ADL LIMITATIONS

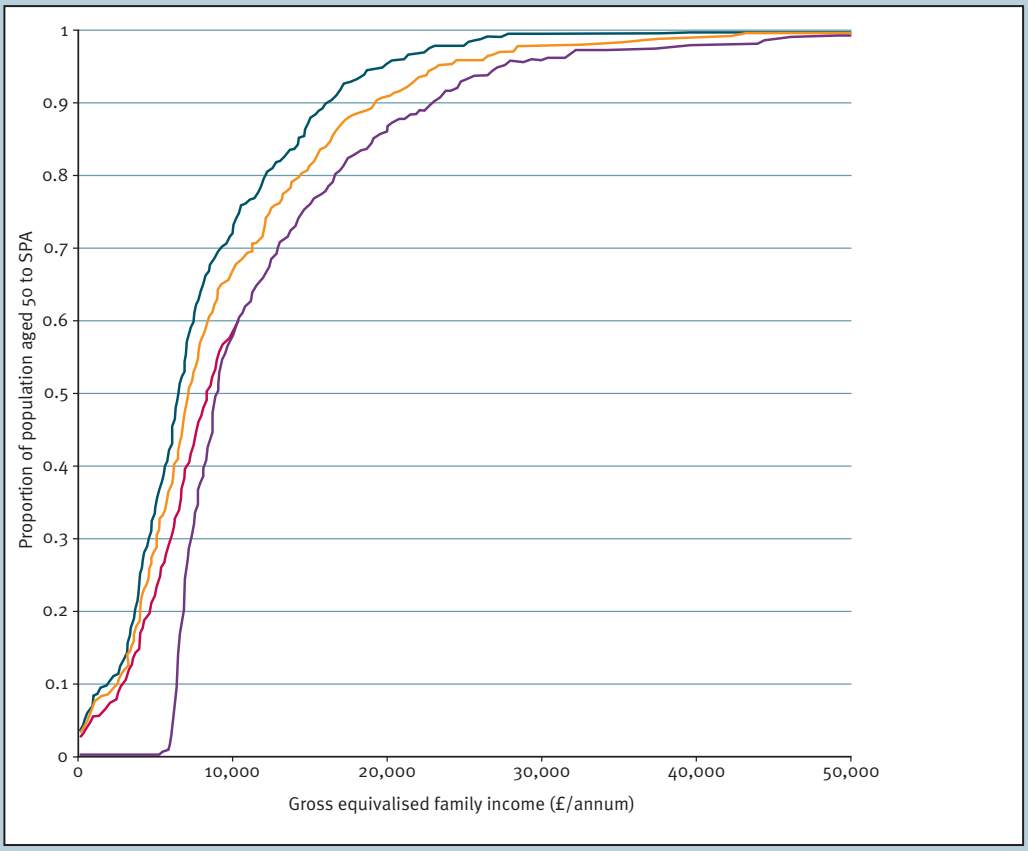


KEY

- Pension wealth
- Non-housing wealth
- Total wealth (including expected inheritance)
- Total wealth plus Pension Credit

Source: Figures prepared using ELSA 2002 data by the Institute for Fiscal Studies for this Review

14 DISTRIBUTION OF PREDICTED RETIREMENT INCOME AT STATE PENSION AGE (SPA) AMONG INDIVIDUALS LIVING ALONE WHO HAVE 1+ ADL LIMITATIONS

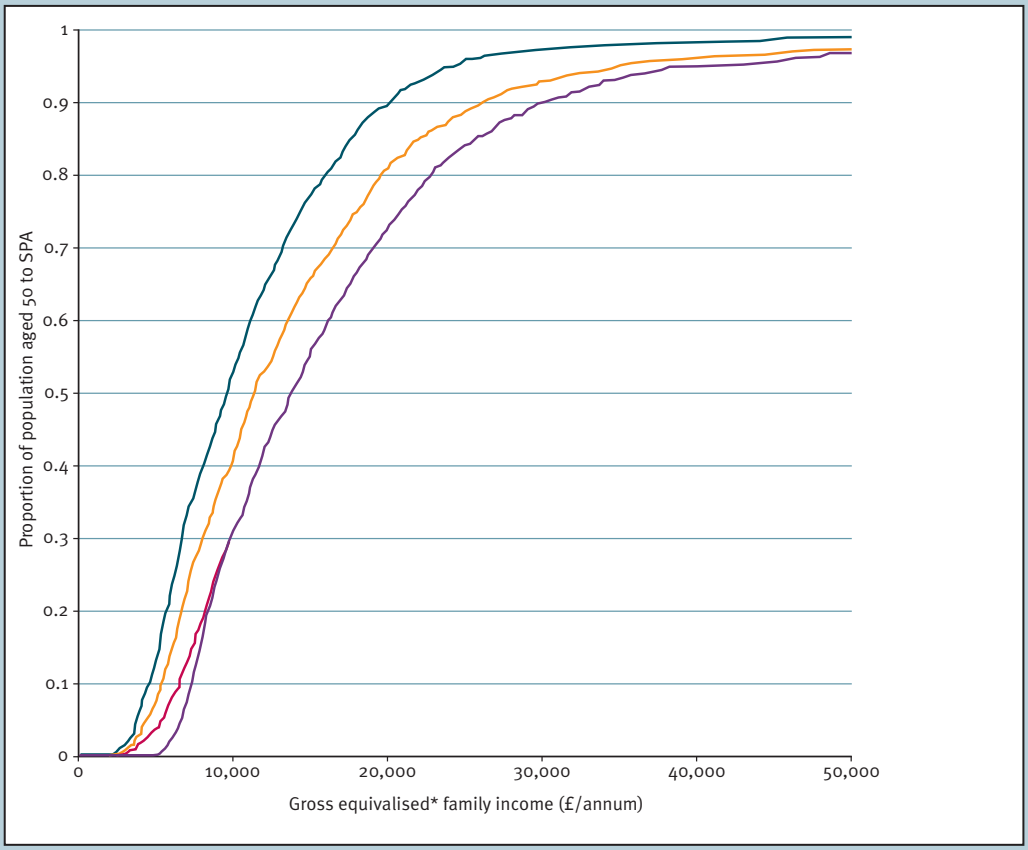


KEY

- Pension wealth
- Non-housing wealth
- Total wealth (including expected inheritance)
- Total wealth plus Pension Credit

Source: Figures prepared using ELSA 2002 data by the Institute for Fiscal Studies for this Review

15 DISTRIBUTION OF PREDICTED RETIREMENT INCOME AT STATE PENSION AGE (SPA) AMONG INDIVIDUALS LIVING WITH OTHERS WHO HAVE NO ADL LIMITATIONS



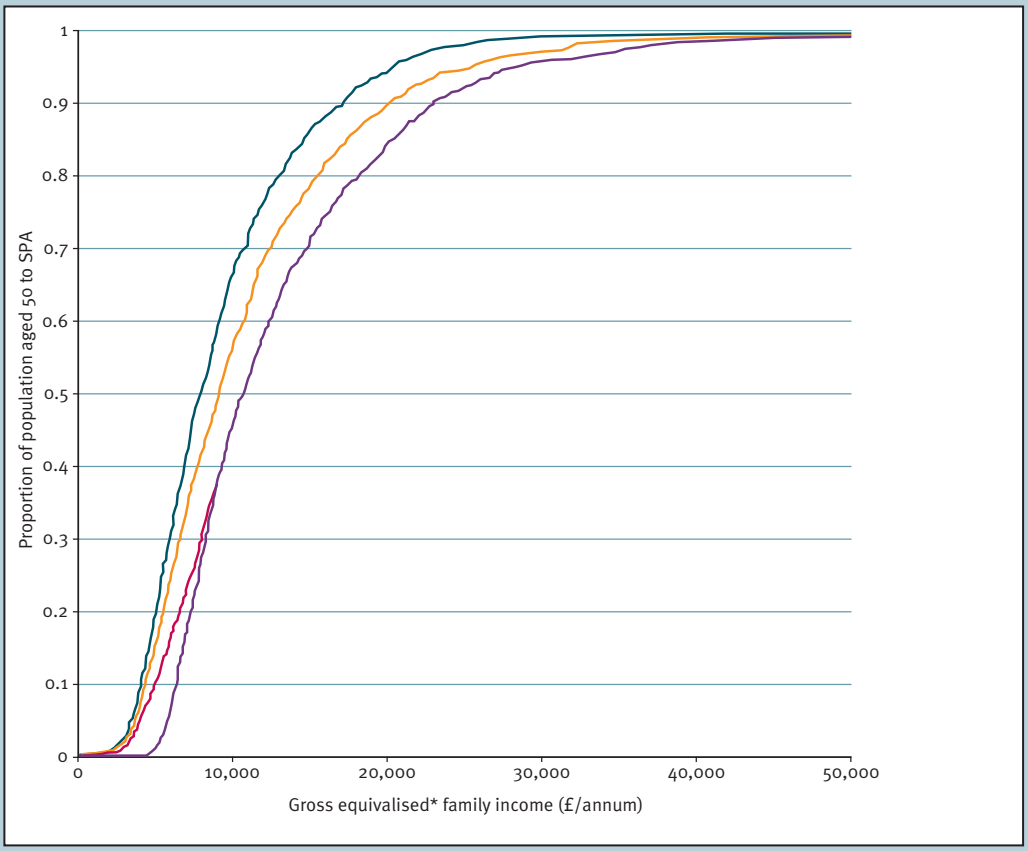
KEY

- Pension wealth
- Non-housing wealth
- Total wealth (including expected inheritance)
- Total wealth plus Pension Credit

Source: Figures prepared using ELSA 2002 data by the Institute for Fiscal Studies for this Review

* The wealth of couples is split 50:50.

16 **DISTRIBUTION OF PREDICTED RETIREMENT INCOME AT STATE PENSION AGE (SPA) AMONG INDIVIDUALS LIVING WITH OTHERS WHO HAVE 1+ ADL LIMITATIONS**



KEY

- Pension wealth
- Non-housing wealth
- Total wealth (including expected inheritance)
- Total wealth plus Pension Credit

Source: Figures prepared using ELSA 2002 data by the Institute for Fiscal Studies for this Review

* The wealth of couples is split 50:50.

In summary, the IFS figures for predicted retirement income suggest a number of key trends regarding the likely future financial health of the baby-boomer generation (those currently aged 50 to SPA).

- Inequality in wealth is more extreme than inequality in incomes.
- Poor health is correlated with lower incomes and lower wealth. A person's predicted retirement income declines as the number of ADL limitations increases. This is true whether or not housing assets are included in the analysis.
- The distinction between whether someone is living alone or with others also results in a gap in predicted retirement income. In most cases, on average a person is better off when living with others.
- Judged by the projected retirement income figures, more than half of those with one or more ADL limitations in this age cohort would not have to contribute to any long-term care costs (domiciliary or residential) under the current means-testing rules.

Financial assets and housing wealth

The retirement income figures in the previous section were based on estimates of future assets. In this section, a snap-shot of current assets is examined, again based on the ELSA survey data collected in 2002. This demonstrates that inequality in wealth across the

elderly population is more extreme than inequality in incomes. As mentioned above, for the total population over 50, the average net financial wealth (not including housing) is more than £40,000, but half this cohort has less than £12,000 and a quarter has less than £1,500 (Banks *et al* 2004).

The four main forms of private wealth are housing, financial assets, non-property physical wealth and pensions wealth (the accumulated pensions savings or entitlement, not the income from a pension). Given the current charging regimes, the most relevant are net financial wealth and net housing wealth. For someone receiving social care in their own home, the means-testing assessment can include all financial assets (depending on the local authority's charging regime) but not the value of the house or flat. For someone admitted to residential care, the CRAG means-testing usually also includes the net value of the home if no spouse or partner remains living in the home.

The distribution of wealth is shown in Tables 16, 17, 18, 19, 20 and 21 categorised by age, gender and ADL limitations. Separate figures are given for total (non-pension) non-housing[4] wealth and housing wealth. (Unlike with the predicted retirement income, pension wealth is not included in any of these figures.)

A large inequality in (non-pension) non-housing wealth is demonstrated for each type of individual (reading horizontally along rows). Also those with two or more ADL limitations have a markedly lower level of (non-pension) non-housing wealth (reading vertically down column sections). In practice, local authority needs eligibility criteria mean that someone with two or more ADL deficiencies would be likely to qualify for social care on needs grounds, so it is the assets of this group that are particularly relevant. For example, with the lower assets means-testing threshold in England at present £12,500 (2005/6), about

TABLE 16: DISTRIBUTION OF TOTAL NON-HOUSING AND NON-PENSION WEALTH AMONG SINGLE MEN, BY AGE AND NUMBER OF ADL LIMITATIONS

Single men	Distribution of wealth (£thousand)											Number of men
	10th pctile	20th pctile	25th pctile	30th pctile	40th pctile	Median	60th pctile	70th pctile	75th pctile	80th pctile	90th pctile	Mean	
Aged 50–59	**-1.0**	**0.0**	**0.0**	**0.2**	**2.1**	**7.3**	**19.4**	**34.8**	**52.6**	**65.0**	**112.0**	**70.7**	**329**
No ADL limitations	-0.9	0.0	0.2	0.5	3.0	11.0	21.5	39.0	57.6	67.2	115.5	82.0	266
1 ADL limitation	-1.7	0.0	0.0	0.0	1.5	7.0	27.0	43.7	87.0	93.4	103.0	34.3	30
2+ ADL limitations	-1.7	-0.8	-0.1	-0.1	0.0	0.0	0.7	3.0	3.1	11.6	34.0	9.8	33
Aged 60–74	**0.0**	**0.2**	**0.8**	**1.3**	**3.5**	**8.0**	**15.4**	**30.3**	**45.9**	**61.0**	**124.3**	**45.2**	**446**
No ADL limitations	0.0	0.3	1.0	2.0	5.0	10.2	19.8	39.9	55.1	72.0	129.0	51.6	345
1 ADL limitation	-0.3	0.3	0.6	1.3	2.0	3.7	8.0	13.0	18.3	23.0	139.5	28.0	49
2+ ADL limitations	-1.2	0.0	0.0	0.0	0.2	1.1	2.9	5.0	10.6	14.9	69.9	17.7	51
Aged 75+	**0.1**	**1.0**	**1.9**	**2.5**	**4.5**	**7.3**	**10.5**	**21.9**	**33.0**	**48.0**	**102.9**	**38.3**	**350**
No ADL limitations	0.2	1.0	1.9	2.5	4.5	8.0	10.5	23.1	35.0	50.0	122.5	43.1	232
1 ADL limitation	0.1	2.1	2.5	3.5	7.9	10.5	16.5	22.7	33.0	47.0	98.0	30.4	58
2+ ADL limitations	0.0	0.3	0.6	1.7	3.4	5.0	7.0	9.0	13.5	28.0	70.9	27.2	60

Source: Prepared for this Review by the Institute for Fiscal Studies using ELSA 2002 data
Note: Pctile = percentile.

TABLE 17: DISTRIBUTION OF TOTAL NON-HOUSING AND NON-PENSION WEALTH AMONG SINGLE WOMEN, BY AGE AND NUMBER OF ADL LIMITATIONS

Single women	Distribution of wealth (£thousand)												Number of women
	10th pctile	20th pctile	25th pctile	30th pctile	40th pctile	Median	60th pctile	70th pctile	75th pctile	80th pctile	90th pctile	Mean	
Aged 50–59	**-1.0**	**-0.1**	**0.0**	**0.0**	**0.4**	**2.5**	**7.1**	**18.4**	**27.4**	**42.8**	**112.0**	**41.9**	**525**
No ADL limitations	-1.0	0.0	0.0	0.1	1.0	3.8	9.1	20.1	28.5	44.0	112.8	44.9	422
1 ADL limitation	-1.3	-0.2	-0.1	-0.1	0.0	0.0	0.2	42.8	46.3	58.8	126.0	41.4	36
2+ ADL limitations	-2.0	-0.4	-0.3	-0.1	0.0	0.0	0.1	0.3	2.7	4.8	61.6	22.8	66
Aged 60–74	**0.0**	**0.2**	**0.6**	**1.3**	**3.3**	**7.2**	**14.0**	**26.0**	**34.0**	**49.1**	**97.4**	**35.5**	**926**
No ADL limitations	0.0	0.5	1.3	2.2	5.0	10.3	17.0	31.4	42.1	54.0	103.0	39.7	682
1 ADL limitation	0.0	0.1	0.2	0.5	2.2	3.4	7.9	18.0	26.0	40.1	92.4	32.7	122
2+ ADL limitations	-0.4	0.0	0.0	0.1	0.4	1.7	3.0	7.0	11.8	17.7	44.9	14.1	120
Aged 75+	**0.1**	**0.7**	**1.0**	**1.9**	**3.0**	**5.2**	**9.0**	**16.5**	**24.6**	**32.0**	**93.5**	**32.3**	**933**
No ADL limitations	0.1	0.8	1.2	2.0	3.6	6.8	12.0	23.0	28.2	39.6	102.0	35.3	554
1 ADL limitation	0.1	0.7	1.0	1.8	3.0	4.5	7.6	12.5	20.0	36.5	99.8	30.6	178
2+ ADL limitations	0.0	0.4	0.8	1.0	2.6	4.0	5.5	9.5	12.0	16.5	51.0	25.9	201

Source: Prepared for this Review by the Institute for Fiscal Studies using ELSA 2002 data
Note: Pctile = percentile.

TABLE 18: DISTRIBUTION OF TOTAL NON-HOUSING AND NON-PENSION WEALTH AMONG COUPLES, BY AGE AND NUMBER OF ADL LIMITATIONS

Couples (jointly)	Distribution of wealth (£thousand)												Number of people
	10th pctile	20th pctile	25th pctile	30th pctile	40th pctile	Median	60th pctile	70th pctile	75th pctile	80th pctile	90th pctile	Mean	
Aged 50–59	**-1.0**	**1.9**	**4.0**	**7.0**	**16.0**	**28.8**	**46.0**	**76.0**	**96.5**	**122.9**	**244.1**	**116.1**	**3,216**
No ADL limitations	-0.5	2.6	5.2	9.0	18.6	33.0	52.3	83.0	105.0	132.0	260.0	120.7	2,845
1 ADL limitation	-2.5	-0.1	0.2	1.0	4.8	13.0	20.8	33.2	42.6	50.8	178.0	132.6	182
2+ ADL limitations	-3.2	-0.7	0.0	0.0	1.1	2.6	10.0	20.5	29.0	42.0	77.7	28.7	186
Aged 60–74	**0.4**	**3.0**	**5.1**	**8.0**	**16.5**	**27.6**	**42.7**	**73.6**	**93.2**	**122.5**	**235.0**	**98.6**	**3,414**
No ADL limitations	0.9	4.6	7.4	10.9	19.9	32.2	49.9	84.0	104.1	134.6	249.0	105.3	2,773
1 ADL limitation	0.0	1.0	1.9	2.6	5.6	13.8	21.0	40.9	48.0	79.5	189.1	65.1	341
2+ ADL limitations	0.0	0.1	1.0	1.2	3.0	7.7	18.0	30.0	40.0	52.0	120.6	64.8	293
Aged 75+	**0.6**	**3.0**	**5.0**	**6.3**	**10.5**	**18.0**	**30.3**	**50.0**	**66.9**	**81.0**	**176.0**	**67.1**	**996**
No ADL limitations	0.7	4.2	6.0	7.6	12.5	22.0	36.0	61.5	72.8	101.0	191.9	74.1	681
1 ADL limitation	1.0	3.0	4.1	6.0	12.0	15.8	23.4	38.0	53.0	74.0	176.0	68.0	153
2+ ADL limitations	0.1	1.0	1.8	2.5	5.0	7.2	15.0	20.1	29.0	44.0	81.0	36.8	162

Source: Prepared for this Review by the Institute for Fiscal Studies using ELSA 2002 data
Note: Pctile = percentile.

TABLE 19: DISTRIBUTION OF HOUSING WEALTH AMONG SINGLE MEN, BY AGE AND NUMBER OF ADL LIMITATIONS

Single men	Distribution of wealth (£thousand)											Number of men
	10th pctile	20th pctile	25th pctile	30th pctile	40th pctile	Median	60th pctile	70th pctile	75th pctile	80th pctile	90th pctile	Mean	
Aged 50–59	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**38.0**	**65.0**	**90.0**	**100.0**	**124.0**	**185.0**	**67.7**	**329**
No ADL limitations	0.0	0.0	0.0	0.0	0.0	45.0	75.0	100.0	113.0	140.0	200.0	74.7	266
1 ADL limitation	0.0	0.0	0.0	0.0	0.0	38.5	80.0	100.0	100.0	100.0	142.0	55.7	30
2+ ADL limitations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	29.0	45.0	60.0	18.9	33
Aged 60–74	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**40.0**	**60.0**	**87.0**	**100.0**	**115.0**	**175.0**	**67.7**	**446**
No ADL limitations	0.0	0.0	0.0	0.0	20.0	50.0	75.0	95.0	100.0	130.0	180.0	76.6	345
1 ADL limitation	0.0	0.0	0.0	0.0	0.0	0.0	30.0	38.7	54.0	57.0	100.0	37.5	49
2+ ADL limitations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	36.5	60.0	80.0	118.0	34.8	51
Aged 75+	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**35.0**	**60.0**	**90.0**	**100.0**	**125.0**	**195.0**	**67.2**	**350**
No ADL limitations	0.0	0.0	0.0	0.0	0.0	40.0	70.0	98.0	120.0	130.0	200.0	72.3	232
1 ADL limitation	0.0	0.0	0.0	0.0	0.0	0.0	40.0	95.0	100.0	110.0	180.0	57.7	58
2+ ADL limitations	0.0	0.0	0.0	0.0	0.0	15.0	52.0	70.0	80.0	95.0	140.0	56.5	60

Source: Prepared for this Review by the Institute for Fiscal Studies using ELSA 2002 data
Note: Pctile = percentile.

TABLE 20: DISTRIBUTION OF HOUSING WEALTH AMONG SINGLE WOMEN, BY AGE AND NUMBER OF ADL LIMITATIONS

Single women	Distribution of wealth (£thousand)											Number of women
	10th pctile	20th pctile	25th pctile	30th pctile	40th pctile	Median	60th pctile	70th pctile	75th pctile	80th pctile	90th pctile	Mean	
Aged 50–59	**0.0**	**0.0**	**0.0**	**0.0**	**12.0**	**42.5**	**74.9**	**100.0**	**124.1**	**140.0**	**180.0**	**74.0**	**525**
No ADL limitations	0.0	0.0	0.0	0.0	30.0	53.0	80.0	110.0	127.0	147.0	191.5	79.0	422
1 ADL limitation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	91.0	95.0	102.0	160.0	45.5	36
2+ ADL limitations	0.0	0.0	0.0	0.0	0.0	0.0	35.0	64.9	75.0	90.0	150.0	57.1	66
Aged 60–74	**0.0**	**0.0**	**0.0**	**0.0**	**36.0**	**65.0**	**90.0**	**115.0**	**130.0**	**150.0**	**200.0**	**87.4**	**926**
No ADL limitations	0.0	0.0	0.0	0.0	45.0	75.0	96.0	120.0	141.0	160.0	230.0	94.9	682
1 ADL limitation	0.0	0.0	0.0	0.0	0.0	42.5	80.0	120.0	140.0	155.0	200.0	79.6	122
2+ ADL limitations	0.0	0.0	0.0	0.0	0.0	28.0	50.0	75.0	82.0	99.0	155.0	52.3	120
Aged 75+	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**43.0**	**72.0**	**98.0**	**110.0**	**135.0**	**200.0**	**74.7**	**933**
No ADL limitations	0.0	0.0	0.0	0.0	15.0	50.0	80.0	100.0	120.0	135.0	200.0	78.3	554
1 ADL limitation	0.0	0.0	0.0	0.0	0.0	26.0	73.0	100.0	139.0	150.0	200.0	72.4	178
2+ ADL limitations	0.0	0.0	0.0	0.0	0.0	0.0	47.5	73.0	90.0	100.0	200.0	66.9	201

Source: Prepared for this Review by the Institute for Fiscal Studies using ELSA 2002 data
Note: Pctile = percentile.

TABLE 21: DISTRIBUTION OF HOUSING WEALTH AMONG COUPLES, BY AGE AND NUMBER OF ADL LIMITATIONS

Couples (jointly)	Distribution of wealth (£thousand)												Number of people
	10th pctile	20th pctile	25th pctile	30th pctile	40th pctile	Median	60th pctile	70th pctile	75th pctile	80th pctile	90th pctile	Mean	
Aged 50–59	**0.0**	**45.0**	**60.0**	**73.0**	**98.0**	**120.0**	**150.0**	**180.0**	**200.0**	**230.0**	**300.0**	**148.5**	**3,216**
No ADL limitations	0.0	51.0	65.0	78.5	100.0	126.0	150.0	186.0	200.0	232.0	304.5	154.0	2,845
1 ADL limitation	0.0	0.0	30.0	46.0	70.0	80.0	104.0	140.0	165.0	190.0	280.0	123.6	182
2+ ADL limitations	0.0	0.0	0.0	0.0	36.0	59.9	90.0	112.7	128.2	152.0	220.0	85.7	186
Aged 60–74	**0.0**	**39.0**	**55.0**	**70.0**	**90.0**	**114.0**	**140.0**	**175.0**	**200.0**	**220.0**	**300.0**	**143.9**	**3,414**
No ADL limitations	0.0	45.0	63.0	75.0	95.0	120.0	150.0	180.0	200.0	230.0	300.0	150.8	2,773
1 ADL limitation	0.0	0.0	35.0	44.0	70.0	90.0	120.0	150.0	160.0	180.0	250.0	120.8	341
2+ ADL limitations	0.0	0.0	0.0	30.0	50.0	70.0	90.0	120.0	140.0	160.0	230.0	97.5	293
Aged 75+	**0.0**	**0.0**	**24.0**	**45.0**	**75.0**	**100.0**	**120.0**	**150.0**	**180.0**	**200.0**	**270.0**	**117.7**	**996**
No ADL limitations	0.0	12.0	42.0	60.0	90.0	110.0	130.0	175.0	200.0	200.0	300.0	129.8	681
1 ADL limitation	0.0	0.0	0.0	20.0	55.0	80.0	110.0	150.0	170.0	190.0	270.0	111.0	153
2+ ADL limitations	0.0	0.0	0.0	0.0	40.0	55.0	80.0	100.0	110.0	125.0	169.0	73.0	162

Source: Prepared for this Review by the Institute for Fiscal Studies using ELSA 2002 data
Note: Pctile = percentile.

75 per cent of single people with two or more ADLs in most age groups have lower net (non-pension) non-housing assets (*see* Tables 16 and 17). They would therefore qualify for state-funded domiciliary social care (unless their income was higher than the limit).

An older person's net housing wealth becomes relevant if they are being means-tested for a residential care home place. The distribution of net housing wealth for single people according to age and ADL limitation is also shown in Tables 19 and 20. The disparities between renters and property-owners will have widened as property prices have increased sharply since 2002 when the ELSA data was collected. As with non-housing wealth, there is great inequality within each category (the horizontal inequality). Similarly, those with higher levels of ADL disability tend to have lower housing wealth (the vertical disparity). The biggest distinction, however, is simply between people who have any net housing assets at all and those who do not. Current property values means that the vast majority of those who have any housing assets that become assessable under the means-testing regime will have to pay for some or all of their residential care home costs. (The housing wealth of most couples (*see* Table 21) would not be assessable for means-testing as long as the partner continued to live in the family home.)

It is misleading to generalise across different age cohorts and between men and women, but by looking at the ELSA data (not reproduced here) for total wealth (non-housing and housing combined), it is possible to get an indication of the proportion of people who could self-fund a care home place from assets (in practice, income would also be used). For example, a stay in a residential or nursing home of two years would incur a cost of more than £38,000 in total on average (at £370 per week). A detailed breakdown of the ELSA figures shows that 20 per cent of single men currently aged 50 to 59 with 2+ ADL limitations appear to have enough total wealth to fund residential care costs over that sort

of time period before their assets are eroded to the upper threshold for means-tested support. For women in the same category, the proportion is more than 30 per cent with the potential to self-fund. For the whole population in this age group, regardless of ADL status, the figure is about 50 per cent. That still leaves a very significant proportion of those currently aged 50–59 and single who appear unlikely to amass a level of assets which would be adequate to fund a care home place (unless through inheritance).

Assets and income of self-funded care home residents

Detailed information is available about the financial status of older people who are self-funding their places in residential and nursing homes (Netten *et al* 2001). (These are people who receive no local authority contribution towards social care costs, although they may receive non-means tested benefits such as Attendance Allowance which they put towards care costs.) By definition, self-funders have a higher financial status than those who qualify for means-tested assistance, but many would probably be unlikely to describe themselves as 'rich'. Some 56 per cent self-funding care home residents had savings and investments (non-housing) below £30,000, and around 53 per cent had weekly incomes below £174 (at time of survey). Overall, a third had total assets of £60,000 or less but nearly two-fifths had assets in excess of £100,000.

The research found that 71 per cent of residents had a weekly income that was insufficient to meet the charges for their care but had assets higher than the means-testing cut-off threshold for state funding. (Around 16 per cent could meet the charges from income alone.) Most self-funding residents had enough assets to last for several years before they had spent down to the means-testing capital threshold. However, a smaller group of residents had levels of assets that would be likely to last for a much shorter period.

Trends from the ELSA data

People aged 50–59 have higher incomes than people over 60. But their non-housing and housing net wealth is generally lower or equal to that of the 60–74 age group, and for those on low incomes there is very little scope to amass increased savings for later life.

ADL limitations start relatively early in life for a significant number of people. The means-testing system limits state-funded social care to those older people with low incomes and little wealth. The income and wealth levels of people aged 50–59 in 'fair/poor' health or with 2+ ADL limitations are already such that a majority of this cohort would be unlikely to amass enough savings over the next 20 years to take them out of the net for state-funded care under the current system. (This ignores the potential for inherited wealth.)

Housing wealth provides a potential source of funds for domiciliary social care for a significant number of people if attractive products were available. However, the level of net housing wealth owned by about half of those over 50 and single with 2+ ADL limitations is either non-existent or would be inadequate to pay for long-term care costs, given that only a proportion of the net housing equity can be released.

Earlier cost projections

Various attempts have been made before this Review to produce projections about the future total expenditure on long-term care for the elderly. These projections each made their own assumptions about the numbers of older people, future dependency rates and unit costs of care. But unlike the modelling in this Review, these earlier studies were mostly based on current patterns of care and funding arrangements, and no allowance was made for changing public expectations about the quality, range or level of care. The results nevertheless provide a useful indication of the level of private expenditure and/or the expected rise in total expenditure on long-term care for older people.

PSSRU/NCCSU model

A number of the projections were prepared by linking the model at the Personal Social Services Research Unit at the London School of Economics with the model at the Nuffield Community Care Studies Unit at the University of Leicester. The most recent results from this combined approach (Wittenberg *et al* 2004) looked ahead to 2051 and, assuming unchanged dependency rates, found that the number of dependent older people in the United Kingdom is projected to grow from around 3 million in 2000 to 6.4 million in 2051. This projection is based on the Government Actuary's Department (GAD) 2002 population projections and updated earlier projections by the same team. Under the central base case scenario, total long-term expenditure was estimated at around £12.9 billion for the United Kingdom (note, not England) in 2000, comprised of £8.8 billion public expenditure (£3.5 billion NHS and £5.3 billion social services) and £4.2 billion private expenditure. The £12.9 billion total for 2000 was projected to rise to £53.9 billion in 2051. The projections of total long-term care spending as a percentage of GDP are given below (Table 22).

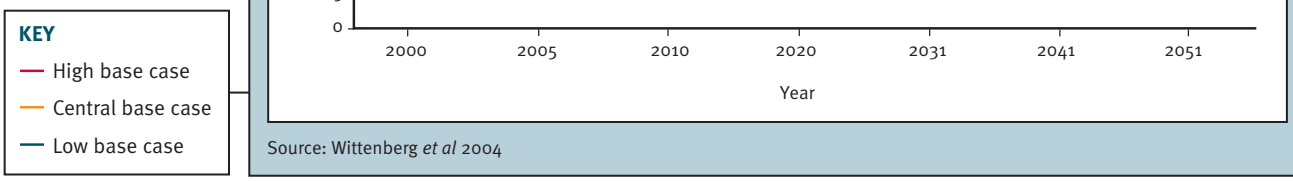
The model found that future long-term care expenditure was highly sensitive to assumed real rises in the unit costs of care. Projections were also made for a low base case and a high base case, which assumed that future numbers of older people would be within the range of the official GAD variant population projections, that dependency rates would *either* remain constant over time or fall gradually, and that the unit costs of care would rise

TABLE 22: PROJECTED EXPENDITURE ON LONG-TERM CARE AS A PERCENTAGE OF GDP, UNDER THE CENTRAL BASE CASE OF THE PSSRU MODEL, 2000 TO 2051

	2000	2005	2010	2020	2031	2041	2051
Public expenditure as % of GDP	0.93	0.92	0.91	0.98	1.14	1.20	1.20
Private expenditure as % of GDP	0.44	0.44	0.47	0.51	0.59	0.62	0.63
All long-term care expenditure as % of GDP	1.37	1.35	1.37	1.49	1.73	1.82	1.83

Source: Wittenberg *et al* 2004

17 **TOTAL EXPENDITURE ON LONG-TERM CARE AS A PERCENTAGE OF GDP UNDER THE LOW, CENTRAL AND HIGH BASE CASE ASSUMPTIONS, UNITED KINGDOM, 2000 TO 2051**



Source: Wittenberg *et al* 2004

in real terms either in line with average earnings or somewhat more slowly. The results are shown in Figure 17. As can be seen, even assuming constant patterns of care and funding, the funnel of doubt is considerable. Not shown in the graph was a scenario that was partially 'carer blind' in giving the most dependent older people who live with others the same packages of non-residential services as those living alone, which under the central base case pushed up total expenditure to around 2.0 per cent in 2051 compared with 1.83 per cent in the original (non-carer blind) projection.

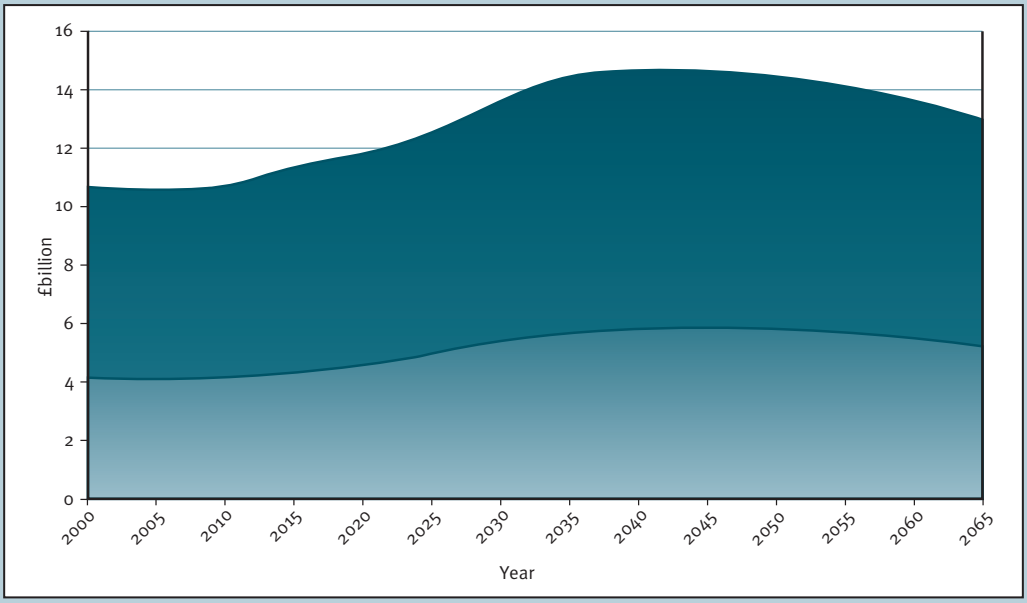
CASS model

A separate set of projections for the United Kingdom was published in April 2004 by the Cass Business School (Karlsson *et al* 2004). The study also used three scenarios: baseline, optimistic and pessimistic. The services modelled were residential and domiciliary care (but, unlike Wittenberg *et al* 2004, did not include long-stay hospital care and community nursing). Cass took a 50-year view, and found that expenditure on formal long-term care under the baseline scenario would increase from £11 billion today to approximately £15 billion by 2040 (in constant prices). Long-term care cost projections under the baseline scenario, split between public and private funding are shown in Figure 18 (*see* overleaf).

The Cass study expressed total costs as a percentage of labour remuneration of the working population, rather than GDP. This implicitly assumes long-term care to be financed out of general (and approximately proportional) income taxes. The results are shown in Figure 19 (*see* overleaf).

The Cass model produces a far less dramatic increase in projected costs in money terms than Wittenberg *et al* (2004). Cass suggests several reasons for this: the projected increases in the disabled elderly population are considerably higher in the PSSRU model; the institutionalised population increases more in the PSSRU model; due to different assumptions regarding the macro economy, these differences do not transmit into the projections of the long-term care sector as a proportion of the economy. Given the significant differences in what the two models include and assume, it is perhaps most useful to note that both baseline projections agree that, for the next 10 years or so, the

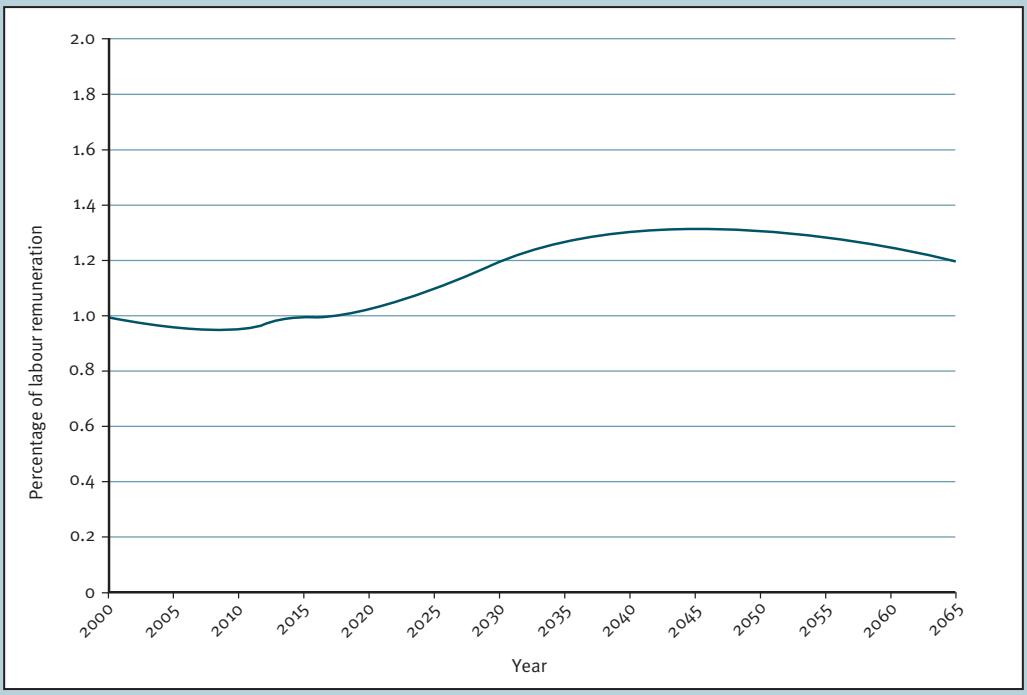
18 LONG-TERM CARE COSTS BY PAYER, UK BASELINE SCENARIO, 2000 TO 2065



KEY
- Out-of-pocket
- Public

Source: Karlsson *et al* 2004

19 IMPLIED CONTRIBUTION RATE FOR LONG-TERM CARE, UK BASELINE SCENARIO, 2000 TO 2065



KEY
- Implied contribution rate

Source: Karlsson *et al* 2004

cost of long-term care as a proportion of the total economy is broadly flat, but from 2015 there is significant increase, reaching a plateau around 2040.

Rising costs of dementia care

Several studies have looked specifically at the impact of dementia impairment on the cost of long-term care, both now and in the future. The estimates and forecasts tend to vary greatly depending on whether they attempt to include the costs of informal care, and on what methodology is used to estimate those costs (McDaid 2001). A summary can be found in Background Paper 9 ('Dementia Care').

Conclusions

Private expenditure by older people on long-term care is large and increasing, yet there is a lack of data on the total amount being spent. For example, there does not appear to be any evidence available about the total amount paid by third parties in top-up fees to care homes, which would be a further useful addition to the data on self-funding. There is particular need for more reliable information on the self-funding of domiciliary care, where the figures that are available appear to be both incomplete and uncertain.

Another important piece of the financial jigsaw which is missing is information about exactly how Attendance Allowance is spent. This benefit is a compensation for disability rather than a payment to cover the costs of services, but it would be useful to know what it is used for. According to analysis by this Review, the majority of claimants living in the community did not report using formal community-based services, which raises the question of how much is used on services that would not be considered traditional social care, such as recreational activities or taxis, and how much is spent helping to meet informal carers' expenses. This would allow consideration of whether this benefit is achieving the desired outcomes, although any moves to link it to the delivery of specific services could conflict with wider aims of greater choice for older people. While this benefit is very popular precisely because it can be obtained without passing through the means-testing process, its role relative to means-tested social care needs to be clarified.

There is both widespread ignorance about the means-testing system and a high level of dissatisfaction about the way it penalises those with relatively modest savings and assets. A number of specific shortcomings in the charging regimes are widely recognised. Some are general problems that would trouble most feasible alternative funding arrangements. Others could be amended within the existing system, for instance by changing means-testing asset threshold levels. But the persisting complaints about eligibility for fully funded NHS continuing care, arise from the more fundamental challenge of managing an interface between a free health service and a means-tested social care system.

Surveys of public willingness to self-fund social care tend to produce inconsistent responses, but there is usually a majority in favour of fully state-funded social care or a universal basic level of provision. In part this arises out of ignorance that social care is not provided on a par with health care, and a feeling that after a lifetime paying taxes an older person's assets should not potentially be drastically eroded by care costs. The challenge for government is that it is often difficult to convey the cost implications of public spending to people, and indeed there is well-known resistance in the general public to increases in general taxation. There *is* some evidence that people are becoming more willing to spend assets rather than passing on an inheritance, but this may not extend to a willingness to pay for social care.

ADL limitations can start relatively early in life for a significant number of people, and disability is correlated with lower resources (both financial and housing). The ELSA income and wealth data for those aged 50 and over demonstrate that under the existing means-tested system there is a large proportion of people who appear destined for state-funded social care in the future. At the same time, there is also a significant proportion of society that is very likely to have to self-fund such care, unless the means-testing regime is eased or abandoned. That being the case, there is the need for comprehensive information about private expenditure on social care.

Annex. Assumptions underlying the predicted retirement income figures

A number of assumptions were made by the Institute for Fiscal Studies when using ELSA data to prepare projected retirement income figures for people between the age of 50 and the state pension age. These were:

General income assumptions

1. All income figures are gross (that is, pre-tax).
2. Annuitisation and income:
   (i) Defined contribution pensions are annuitised at gender- and age-specific annuity rates.
   (ii) State pension income figure is the actual income (assuming state pensions remain indexed to prices at 2.5 per cent annual increase).
   (iii) Defined benefit pensions – income figures are 'fractions' of final salary according to years worked.
   (iv) Housing wealth: 50 per cent of the value is annuitised at 5 per cent (or 100 per cent annuitised at 2.5 per cent).
   (v) All other non-pension, non-housing wealth is annuitised at 5 per cent.
3. No earned income is included after State Pension Age (SPA).
4. Attendance Allowance/Disability Living Allowance are not included. No state benefits other than Pension Credit are included.
5. Health/ADL limitations are assumed to remain constant between the ages of 50 and 65.
6. Single people remain single; couples do not split up (and are not bereaved).
7. As the income figure is income on retirement, there is no consideration of the implications for someone whose spouse dies at some point after retirement.
8. Annual inflation is 2.5 per cent.

Household type and equivalisation

1. All dependent children will have become independent by the time the person reaches SPA. So they are not included when equivalising, that is, when adjusting for whether the family unit contains more than one person.

Living alone include

1. A single adult who is currently living with dependent children (whom it is assumed, as stated above, will have left home by the time the adult reaches SPA).
2. A single parent who currently has a non-dependent child living with them as a 'lodger' (that is, the parent owns the home. It is assumed the child will have moved out by the time the adult reaches SPA).

Living with others

1. An adult living with another/other adults (be they a spouse or otherwise).
2. An adult currently 'lodging' with a non-dependent child. (That is, the non-dependent child owns the home. It is assumed that the adult will continue to live in the child's home on reaching SPA.)
3. In summary, Living with others = (living with anyone other than a dependent/non-dependent child) OR (living with a non-dependent child, where the dependent child is the householder).

Endnotes

[1] This does not include £900,000 in the Disability Living Allowance mobility component. All figures are provided by the Department of Work and Pensions.

[2] Assumptions for care home charges are as follows.

a) Pension Credit and tariff income calculations are (unrealistically) redone every month.
b) Savings/financial assets do not produce any income, nor is any vacated property rented out.
c) All calculations assume benefits, prices and charging rules as at 2005/6.
d) Self-funders only allow themselves £18.80 a week of personal spending money, in line with those who are state-funded.
e) A self-funder provides that £18.80 a week out of savings, whereas anyone who is state funded keeps £18.80 of his/her pension income.
f) Care home fees are the same for both self-funders and those who are state funded.
g) The £450 a week does not include any nursing care.
h) Before moving into the care home, everyone receives Attendance Allowance at the higher rate of £60.60 a week.
i) All the older people are single, aged 65+, and any housing assets are included in the financial assessment.

[3] Assumptions for domiciliary care charges are as follows.

a) All get Attendance Allowance at the higher rate of £60.60 a week.
b) Council tax = £12 a week.
c) Someone receives Carer's Allowance for looking after the person.
d) 14 hours a week (2 hours each day) of personal care is awarded.
e) £5 a week is charged for the community alarm.
f) 0–3 loads of laundry are carried out each week.
g) £3 a week is charged for heating.
h) Both councils implement any maximum threshold for charges.
i) Councils charge at their own hourly rate.

[4] Non-housing wealth includes physical wealth such as second homes, farm or business property, business wealth, land, antiques, works of art and jewellery. Under means-testing rules, the last three of these item types would not be included when assessing an older person's assets.

References

Abbott S, Hobby L, Cotter S (2006). 'What is the impact on individual health of services in general practice settings which offer welfare benefits advice?' *Health and Social Care in the Community*, vol 14, no 1, pp 1–8.

Age Concern England (forthcoming). 'Paying for Personal Care in Later Life'. Focus groups.

Audit Commission (2000a). *Charging with Care: How councils charge for home care*. London: Audit Commission.

Banks J, Karlsen S, Oldfield Z (2004). 'Socio-economic position'. *Health, Wealth and Lifestyles of the Older Population in England: The 2002 English Longitudinal Study of Ageing,* ch 3. London: Institute for Fiscal Studies. Available online at: http://www.ifs.org.uk/elsa/report_wave1.php (accessed on 10 March 2006).

Deeming C (2001). *A Fair Deal for Older People: Public views on the funding of long-term care*. London: King's Fund.

Deeming C, Keen J (2002). 'Paying for old age: can people on lower incomes afford domiciliary care costs?' *Social Policy & Administration*, vol 36, no 5, pp 464–81.

Deeming C, Keen J (2003). 'A fair deal for care in older age? Public attitudes towards the funding of long-term care'. *Policy and Politics*, vol 31, no 4, pp 431–46.

Department of Health (2001a). *Health and Social Care Joint Unit: Free Nursing Care Frequently Asked Questions*. London: Department of Health. Available online at: http://www.dh.gov.uk/assetRoot/04/07/80/32/04078032.PDF (accessed on 10 March 2006).

Department of Health (2002). *Tough Package of Measures to Ensure Care Home Residents Benefit from NHS Nursing Care*. London: Department of Health. Available online at: http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4013086&chk=cWgtEy (accessed on 10 March 2006).

Department of Health (2003). *Fairer Charging Policies for Home Care and other Non-residential Social Services: Guidance for councils with Social Services responsibilities*. London: Department of Health. Available online at: http://www.dh.gov.uk/assetRoot/04/10/72/94/04107294.pdf (accessed on 4 November 2005).

Department of Health (2005a). *Charging for Residential Accommodation Guide (CRAG)*. London: Department of Health. Available online at: http://www.dh.gov.uk/assetRoot/04/10/72/94/04107294.pdf (accessed on 4 November 2005).

Department of Health (2005b). *Personal Social Services expenditure and Unit Costs: England: 2003–2004*. London: Department of Health. Available online at: http://www.dh.gov.uk/assetRoot/04/10/40/01/04104001.pdf (accessed on 4 November 2005).

Department of Trade and Industry (2005). *Response to Office of Fair Trading Care Homes Study.* London: DTI. Available online at: http://www.dti.gov.uk/ccp/topics2/pdf2/N0000C69.pdf (accessed on 4 November 2005).

Hancock R, Comas-Herrera A, Wittenberg R, Pickard L (2003). 'Who will pay for long-term care in the UK? Projections linking macro- and micro-simulation models'. *Fiscal Studies,* vol 24, no 4.

Hancock R, Pudney S, Barker G, Hernandez M, Sutherland H (2004). 'The take-up of multiple means-tested benefits by British pensioners: evidence from the family resources survey'. *Fiscal Studies*, vol 25, no 3.

Health Committee (2005). *Sixth Report.* London: The Stationery Office.

The Health and Social Care Act (2001). Available online at: http://www.opsi.gov.uk/acts/acts2001/20010015.htm (accessed on 5 March 2006).

Hirsch D (2005). *Facing the Cost of Long-Term Care: Towards a sustainable funding system*. York: Joseph Rowntree Foundation. Available online at: http://www.jrf.org.uk/bookshop/eBooks/1859353894.pdf (accessed on 10 March 2006).

Karlsson M, Mayhew L, Plumb R, Rickayzen B (2004). *An International Comparison of Long-Term Care Arrangements: An investigation into the equity, efficiency and sustainability of the long-term care systems in Germany, Japan, Sweden, the United Kingdom and the United States.* London: Cass Business School. Available online at: http://www.cass.city.ac.uk/arc/reports/ARP%20156.pdf (accessed on 8 November 2005).

Laing & Buisson (2005a). *Care of Elderly People: Market survey 2005*. London: Laing & Buisson.

Laing & Buisson (2005b). *Domiciliary Care Markets 2005.* London: Laing & Buisson.

McClimont B, Grove K (2004) *Who Cares Now? An updated profile of the independent sector home care workforce in England*. Carshalton Beeches: UK Home Care Association. Available online at: http://www.ukhca.co.uk/pdfs/whocaresnow.pdf (accessed on 8 November 2005).

McDaid D (2001). 'Estimating the costs of informal care for people with Alzheimer's disease: methodological and practical challenges'. *International Journal of Geriatric Psychiatry*, vol 16, no 4, pp 400–405.

Netten A, Darton R, Curtis L (2001). *Self-funded Admissions to Care Homes.* London: PSSRU for DWP.

Netten A, Darton R (2003). 'The effect of financial incentives and access to services on self-funded admissions to long-term care'. *Journal of Social Policy & Administration,* vol 37, no 5, pp 483–97.

Office of Fair Trading (2005). *Care Homes for Older People in the UK: A market study.* London: Office of Fair Trading.

Parker P, Clarke H (1997). 'Will you still need me, will you still feed me? Paying for care in old age'. *Journal of Social Policy & Administration*, vol 31, no 2, pp 119–35.

Pensions Policy Institute (2005). *A Commentary on the Pension Reform Debate.* London: Pensions Policy Institute.

Robinson J, Banks P (2005). *The Business of Caring: King's Fund Inquiry into Services for Older People in London*. London: King's Fund.

Rowlingson K, McKay S (2005). *Attitudes to Inheritance in Britain.* London: Joseph Rowntree Foundation.

Royal Commission on Long-term Care (1999). *With Respect to Old Age: Long Term Care – Rights and Responsibilities*. London: The Stationery Office

Stoddart H, Whitley E, Harvey I, Sharp D (2002). 'What determines the use of home care services by elderly people?' *Health and Social Care in the Community*, vol 10, no 5, pp 348–60.

Thompson P, Matthew D (2004). *Fair Enough? Research on the implementation of the Department of Health Guidance Fairer charging policies for home care and other non-residential social services.* London: Age Concern.

Wittenberg R, Comas-Herrera R, Pickard L, Hancock R (2004). *Future Demand for Long-term Care in the UK: A summary of projections of long-term care finance for older people to 2051.* York: Joseph Rowntree Foundation.

Wright F (2002). *Asset Stripping: Local authorities and older homeowners paying for a care home place*. Bristol: Policy Press.

Wright F (2003). 'Discrimination against self-funding residents in long-term residential care in England'. *Ageing & Society*, vol 23, pp 603–24.