Editorials

Funding for social care:

the continuing conundrum

The question of how to fund long-term care of older and disabled people has long confounded politicians across the developed world. While health care in England has been 'free at the point of delivery' since 1948, social care has been subject to means-tested charges. Last autumn the coalition government asked Andrew Dilnot, an Oxford economist, to come up with new proposals. Dilnot's commission has recently reported.[1] Has he anything new to propose and why does this matter to general practice?

SUPPORTING THE AGEING POPULATION

Long-time observers of social policy will be familiar with previous reviews,[2–4] notably the Royal Commission on Long Term Care which reported in 1999.[2] The failure to make progress is easily explained. Calls for free personal care, whatever the situation north of the border, were never likely to garner support from the English exchequer. (Following the introduction of free personal care in Scotland in 2002, there has been a substantial increase in demand for care which cannot be explained by demographic trends, higher rates of disability, or reductions in informal care.[5]) Dilnot thinks that the state should pay more for social care; but so must we. In specifying how — and with a degree of realism — his report represents an advance.

Reading earlier reports, one is struck by the commonality of concerns and phraseology. All parties agree that the current system is 'confusing, unfair and unsustainable.'[1] Many people's last years are blighted by fear of penury. They are unable to plan ahead to meet their future care needs. This is the only area where people cannot pool their risks and protect themselves against future high-cost care through insurance. Home and residential care is free only to those with assets worth less than £23 250. In other words, many people of moderate means are affected and have to sell their homes to support living. According to Dilnot, 1 in 10 people aged 65 years face future lifetime care costs in excess of £100 000 while half can expect to spend more than £20 000.[1]

Dilnot's solution is to limit an individual's maximum contribution to between £25 000 and £50 000. The commission thinks that £35,000 is an appropriate and fair figure. The asset threshold for those in residential care beyond which no means-tested help would be given would rise to £100 000. Those who enter adulthood with needs for continuing support should be immediately eligible for free care rather than being subject to a means test.

The commission recommends that people should contribute a standard amount — between £7000 and £10 000 per year — towards their living costs, such as food and accommodation, in residential care. Eligibility criteria for service entitlement should be set on a standardised, national basis in England to improve consistency and fairness, and there should be portability of assessments. Finally, the system should be more 'carer-sighted' in taking account of the demands on carers and their needs.

As a result, more people would receive significant help and no one would lose more than 30% of their total assets (Figure 1). It is anticipated that only a minority would spend their entire £35 000, beyond which everyone's care costs would be covered. Figure 2 shows the distribution of costs for those entering care in 2009/2010, what would be borne by the state and what by individuals.

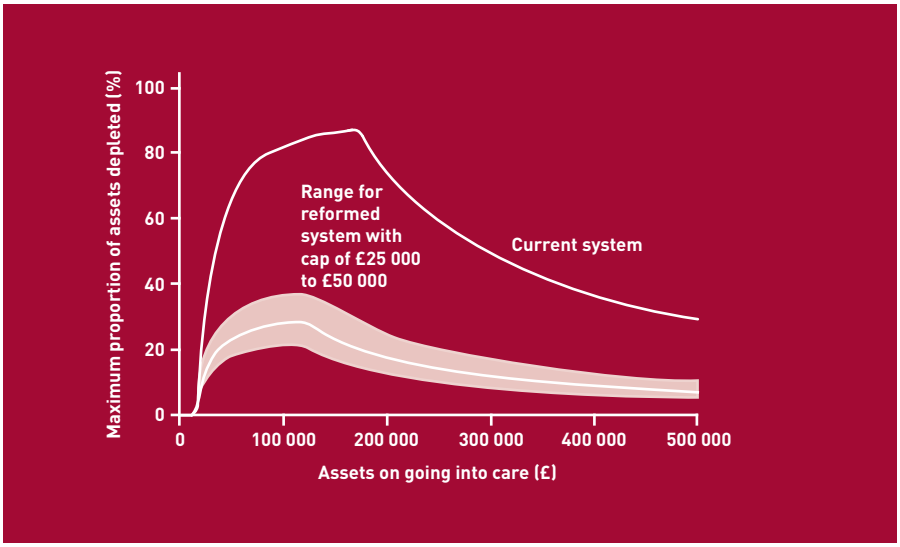
Such changes would need to be accompanied by a major information strategy, if only to guide consumers through the myriad new financial services and products that are expected to emerge in their wake. These reforms would necessitate the realignment of benefits such as Attendance Allowance (a benefit for people aged 65 or over who have an illness or disability and need help with personal care).

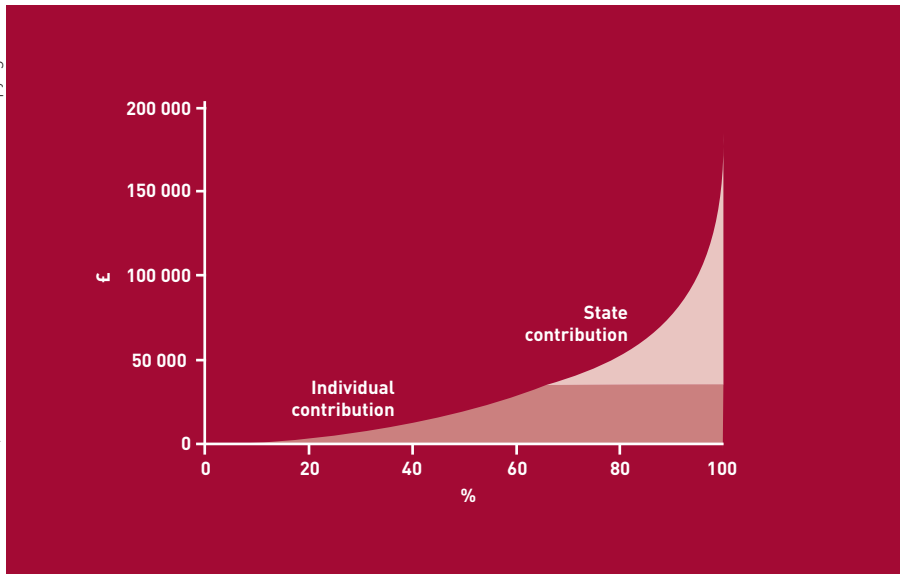
All this would be costly for the state, however: an extra £3.6 billion pounds annually by 2025. Furthermore, the distribution of benefits appears regressive.[6] (In proportionate terms, the reforms would lead to greater expenditure on older people higher up the income distribution.) With the costs of social care and associated benefits already projected to rise by £6.5 billion over the next 10 years,[1] the government will seek to reduce the costs of any changes. They could do this by establishing a cap of at least £50 000, raising the proposed £100 000 threshold for means testing or reducing the availability of other benefits. These are, after all, the first exchanges in an engagement that is supposed to produce a White paper early next year.

IMPLICATIONS FOR GPs

The importance of this issue for general practice is self-evident. Health professionals in the community are frequently made aware of the devastating impact of existing arrangements. The ability to plan ahead and take at least some control over events during the least predictable period of life would provide otherwise vulnerable older people great reassurance. GPs will need to be able to play a more

Figure 1. Maximum possible asset depletion under our core proposals for people who enter residential care and have lifetime care costs of £150 000.[1]





Source: ESHCRU/PSSRU microsimulation model. © Crown copyright 2011.

Figure 2. Lifetime care costs met by the individual and the state under a £35 000 cap, for people entering care, by percentile.[1]

active role in guiding their patients to local sources of information, advice, and support when appropriate.

The potential impact on GPs in their expanding role as commissioners of health and social care is harder to gauge. Simply standardising eligibility criteria for service entitlement on a national basis and encouraging people to plan ahead for their later life needs will make their job easier.

FAULTLINES

The Dilnot commission will dissatisfy long-time champions of unified funding. The root problem remains the artificial demarcation between two forms of care. For some, the very phrase 'social care' demeans older people by detaching the source and solution of their suffering from disease and frailty. The arguments against continuing to separate personal and nursing care remain strong.[7] The privatisation of long-term care has been accompanied by fragmentation of services and inefficiency. Experience from Scandinavia suggests that fully-funded systems are more cohesive and less costly.[8] Unfortunately, realpolitik at a time of unprecedented pressure on public finances suggests that no government will commit to funding social care in the near future.

The report rather glosses over the daunting procedural complexities of a capped care scheme; for example, multidisciplinary assessments, costing packages of care, national tariffs, oversight, and arbitration. The perverse incentive to define intimate personal care as not requiring nursing expertise distances older people from the skills they properly need. This will persist without further work to integrate funding streams. (Interestingly, Scotland has seen a shift of costs from health to social care and the emergence of substantial unmet need.[5]) The commission took account of deliberative research into the needs of specific groups in coming up with its proposals, but rigorous, independent evaluation of their impact on different populations must accompany future developments.

THE CHANGING SOCIAL CONTRACT

The boundaries of the state are being redefined as society becomes more affluent. (The median property and savings wealth of a woman aged 75 to 84 years is £124 000.[1]) Politicians receive mixed messages from their electorates but they are probably correct in discerning widespread public acceptance of the principle of taking responsibility for costs up to a point past which the state pays. (Twenty-five percent of women in the same age group have assets worth less than £5000.)

This settlement requires us to trade purity for pragmatism. If implemented, these proposals ought to improve the status quo. Contingent risks would be pooled in a universal manner so reducing the threat of financial devastation for many older people. However, this type of social insurance policy, with a significant 'excess' which people will need to cover themselves, may provide a model for the future funding of the NHS.

Significant reforms are unlikely within the life of this parliament — the government may yet decide to kick this issue into the long grass — but let us hope that Dilnot's proposals fare better than his predecessors'. For in ways we may not yet wish to think on, they will affect all of us.

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