Future of Paying for Social Care in Wales

First report to the Welsh Government

April 2014
About LE Wales

LE Wales is an economics and policy consultancy based in Wales and is a division of London Economics. London Economics is one of Europe’s leading specialist economics and policy consultancies with offices in Cardiff, London, Brussels, Dublin, and Budapest, and associated offices in Paris and Valletta.

We advise private and public sector clients on economic and financial analysis, policy development and evaluation, business strategy, and regulatory and competition policy. Our consultants are highly-qualified economists with experience in applying a wide variety of analytical techniques to assist our work, including cost-benefit analysis, multi-criteria analysis, policy simulation, scenario building, statistical analysis and mathematical modelling.

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**Terminology abbreviations**

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<tr>
<td>LA</td>
<td>Local Authority</td>
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<td>LHB</td>
<td>Local Health Board</td>
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**Definitions**

<table>
<thead>
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<tr>
<td>Non-residential care</td>
<td>Care services provided in the community to clients living at home</td>
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<td>Residential care</td>
<td>Care and accommodation services provided to clients living in a care home</td>
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Executive summary

The Welsh Government has committed to introduce reform of the arrangements for paying for social care in Wales. As part of the policy development process, the Welsh Government has commissioned LE Wales to undertake an independent research study on the future of paying for care in Wales.

This report sets out those elements of the evidence base that have been collected and collated to date in line with the contract specification set by the Welsh Government. The main aim for this first stage of our work has been to start to build up the evidence base for use in the second stage of our work. This means that this report represents work in progress and does not include any advice or conclusions on specific policy options or their impacts.

A second report will include further work that will take place over the coming months with the report due to be completed by September 2014. This second stage of our work will involve:

- further desk research to collect data for use in the assessment of option impacts;
- the collection of additional data from Welsh local authorities and, potentially, from other service providers;
- 5-10 additional telephone interviews with stakeholders;
- an assessment of the potential impacts of a range of paying for care options.

In the remainder of the executive summary we present our summary of this first report.

Future need for social care services

Population projections for Wales suggest that the numbers of people aged over 65 will increase over the next 25 years. The proportion of the Welsh population that is over 65 will also increase. ONS projections suggest that by 2037 the number of people aged over 65 (over 85) in Wales will be around 47% (10%) of the working age population, compared to around 30% (4.5%) now.

If existing rates of prevalence for various health conditions and care needs are applied to this changing demographic structure of the population, then this implies significant increases in the need for social care services in future. However, improvements in health and care services, including better prevention, could play a role in counteracting some of these pressures.

Existing provision of social care services

On average, about 1.5% of adults aged 18-64 and about 14% of over 65s in Wales receive local authority social care services. For those aged over 65, the proportion receiving care services increases significantly with age, with almost half (48%) of those aged over 85 receiving local authority social care services. These figures for working age adults have stayed broadly constant over the last six or seven years, whilst the proportion of over 65s receiving local authority social cares services has declined slightly, from 15.3% in 2006/07. Typically, around three-quarters of these users make use of non-residential care services and a quarter use residential services. Over the last few years there has been a slight upward trend in the number of non-residential care users and a slight downward trend in the number of residential care users in both age groups.
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These data do not include information about individuals who arrange and fund their care independently of the local authorities. Accurate information about these ‘self-funders’ is not available, though we will seek to make estimates for Wales during the second stage of this work. There may well be a significant number of these self-funders that are not captured here. For example, it has been estimated that in England, 43% of individuals staying in care homes were fully self-funded in 2013, and that 19% of non-residential care users were fully self-funded in 2006.

Expenditure on local authority social care services in Wales was £1,325m in 2012/13, about 2.8% of Welsh GDP. About 13% of this cost was recovered from charges paid by service users.

Charges for non-residential social care services

Local authorities have a high degree of discretion in the level of charges paid by service users for non-residential care services that they receive if their care needs meet the eligibility requirements. According to national regulations the only services they have to provide free of charge are:

- Transport to and from a day centre, where this forms part of their care need assessment;
- Aftercare Services provided under Section 117 of the 1983 Mental Health Act;
- Services provided to sufferers of Creuzfeldt Jacob Disease;
- Intermediate care services (reablement services) for 6 weeks following a stay in hospital;

For all other services provided local authorities have discretion in setting the level of care charges. In April 2011, the Welsh Government introduced a maximum weekly charge for users in receipt of non-residential care services. The maximum weekly charge was set at £50 in April 2011 and remained at that level for the following three years before increasing to £55 in April 2014. A further rise to £60 has been announced for April 2015.

The level of charges for individual services is still significantly different across the local authorities. Rates for home care, for example, range between £6.67/hour and £20.84/per hour. However, the presence of a maximum weekly charge ensures that users of non-residential care services in Wales will not have to pay a weekly charge beyond that level. It also reduces the variation in the total amounts that service users pay each week.

Charges for residential social care services

Individuals who need to move to a care home are subject to a financial assessment to determine whether they are eligible for public support. For example, individuals with less than £24,000 in all savings and assets (including property) are eligible for public support and none of their assets will be taken into account in the financial assessment. They will be asked to contribute towards the cost of care based on their weekly income, subject to a minimum guaranteed income (Personal Expenses Allowance) of £25.

Local authorities set annually the maximum contribution they will pay to independent care homes providing residential care services and the fees for local authority care homes. The fees cover both care and living accommodation costs in care homes. The fee level varies according to residents’ type of need and the services provided by the care homes. For individuals receiving nursing care services the Local Health Board provides a contribution towards those costs, which is currently set at £120.56 per week across most Welsh health boards. Residents in residential and nursing care
homes are then required to contribute to the weekly fee with amounts varying according to their income.

**Deferred payment schemes**

In order to avoid requiring individuals to sell their property during their lifetime, local authorities can offer home owners who move into residential accommodation and who do not have sufficient income and other assets apart from their home the option to defer the care charges. Under a deferred payment scheme, the local authority will pay the residential care fees in full and put a legal charge (similar to a mortgage) on the care home resident’s property. Care home residents are still required to pay a contribution to the local authority based on their eligible income (and subject to the personal expenses allowance). The local authority will then recover the money when the property is sold (before or after the death of the resident) or if the resident decides to terminate the agreement.

In Wales, local authorities are required to have a deferred payment scheme in place. However, the characteristics of the deferred payment scheme and whether to enter into specific agreements are left to the discretion of each local authority. One of the key features of the schemes is the current inability of local authorities to charge any interest during the life of the agreement, meaning that the scheme is run at a loss. This may mean that local authorities have limited incentive to promote deferred payment schemes.

Overall, most Welsh local authorities report a very low number (less than 10 per year) of new deferred payment agreements started in each of the last three years. Only in 4 local authorities was the average number of new agreements more than ten in the last three years, with two local authorities recording almost 30 new deferred payments in 2013/14.

**Care-related financial products**

The only significant insurance product currently available specifically for care costs in the UK is an immediate-needs annuity. There is no public information about the level of take up of care-related financial products in Wales. Our stakeholder consultation suggests that take up of immediate needs annuities may be relatively low in Wales. For one immediate-needs annuity provider serving the UK, only 2% of policyholders are based in Wales (one would expect this figure to be approximately 5% if the number of policyholders were proportional to the population).

Looking to the future, there are a number of potential financial products, new products as well as revisions to existing products, specifically aimed at social care that could be introduced or re-introduced into the marketplace. Before the introduction of new products, public awareness of social care costs and the potential need for individuals to contribute towards them may well need to be improved. Suggestions of how this could be done include incorporating social care considerations into later-life planning in general and having local authorities signposting potential consumers of care-related financial products to independent financial advisers.

**Paying for care: alternative models**

Most people who need social care services are elderly. Before reaching this stage in their lives, people cannot usually anticipate with any certainty whether or not they will ever need social care services and, if they were to need them, when that would be and what type and volume of services they would need, as well as how much those services might cost. Even for those with
Executive summary

Sufficient income to save towards, and pay for, potential future care costs, these uncertainties make planning ahead for care very difficult. The costs of care services can be high and many on low incomes would not be able to pay for suitable care services themselves.

These types of problems lend themselves to risk pooling mechanisms. Governments derive most of their revenues through the tax system, which most citizens contribute towards. Where the State pays for social care services, this could be viewed as a type of risk pooling or insurance mechanism that spreads the risks of needing to pay for care across the population. This mechanism can also take account of differences in income and wealth. A slightly different risk pooling mechanism that is used in some countries is a specific national insurance fund which citizens pay into and which then makes payments for the care services required by citizens. In this system there would be a link between the total amount that citizens pay into the fund and the total expenditure on care services, though there would not necessarily be a link between the amounts that individuals pay and the value of care services that they receive. Risk pooling can also occur through private insurance schemes and other types of financial product.

In this report we provide descriptions of the paying for care systems for eight other countries: England, Scotland, Northern Ireland, France, Germany, Sweden, Japan and Australia. In these countries care costs are funded through mixed public-private models involving various combinations of private and public payments. Typically, users contribute between 5% and 30% of care costs, though as citizens they will also contribute additional amounts through the tax system and/or through enrolment in long term care insurance schemes (compulsory in Japan and Germany).
1 Introduction and Background

1.1 Scope and approach to the research

The Welsh Government has committed to introduce reform of the arrangements for paying for social care in Wales. As part of the policy development process, the Welsh Government has commissioned LE Wales to undertake an independent research study on the future of paying for care in Wales. LE Wales will gather and analyse available information relevant to the future of paying for care in Wales and use this information to undertake an appraisal of the options for reform.

This report sets out those elements of the evidence base that have been collected and collated to date in line with the contract specification set by the Welsh Government. The main aim for this first stage of our work has been to start to build up the evidence base for use in the second stage of our work. This means that this report does not include any advice or conclusions on specific policy options or their impacts.

Our work to date has involved:

- desk research, drawing on published reports and articles, web-based material and published statistics;
- a short survey of local authorities in Wales, undertaken in March 2014, to collect information about charges for social care and deferred payments schemes (for Chapters 3 and 4);
- six telephone interviews with stakeholders in the financial services sector, undertaken in March and April 2014, to discuss existing and potential future financial products with a link to paying for social care services. Discussions were held with product providers (for example, insurers), intermediaries (insurance brokers) and trade associations.

An overview of the contents of this report is provided in the next section below.

A second report will include further work that will take place over the coming months with the report due to be completed by September 2014. This second stage of our work will involve:

- further desk research to collect data for use in the assessment of option impacts;
- the collection of additional data from Welsh local authorities and, potentially, from other service providers;
- 5-10 additional telephone interviews with a wider range of stakeholders;
- an assessment of the potential impacts of a range of paying for care options.

1.2 Contents of this report

In Chapter 2 we use data collected by local authorities and published by the Welsh Government to present a picture of:

- the number of people who received adult social care services from Welsh local authorities (either directly, or through private or third sector providers where that provision has been funded by Welsh local authorities);
- local authority spend on those services; and
1 | Introduction and Background

- the revenue that local authorities receive from charges for those services.

These data do not include information about individuals who arrange and fund their care independently of the local authorities. Accurate information about these ‘self-funders’ is not available, though we will seek to make estimates for Wales during the second stage of this work. There may well be a significant number of these self-funders that are not captured in the data presented in Chapter 2. For example, it has been estimated that in England, 43% of individuals staying in care homes were fully self-funded in 2013,\(^1\) and that 19% of non-residential care users were fully self-funded in 2006.\(^2\)

Chapter 3 summarises the way in which local authorities charge services users for social care services and also provides information about the levels of those charges. Our information on charges is derived from local authority websites and also a short questionnaire that was sent to local authorities during March.

Chapter 4 provides information about the use of deferred payment schemes in Wales and in England. This information was drawn from desk research, including Welsh local authority websites, and our questionnaire for Welsh local authorities.

Chapter 5 provides information about the financial products that are currently available and that may be useful for service users wishing to pay for care services and also discusses prospects for changes in the availability of such financial products. This draws on desk research supplemented by six telephone interviews with stakeholders in the financial service sector. Discussions were held with product providers (for example, insurers), intermediaries (insurance brokers) and trade associations.

Finally, Chapter 6 provides a high level overview of alternative models for paying for care, drawing on the experiences of other countries, including other parts of the UK.

1.3 Population trends in Wales

In Figure 1 we present the recent trend for the Welsh population in each age group (18-64 and 65 plus). The population aged 18 to 64 increased from 1,818,000 to 1,857,000 (with a net increase of around 39,000) between 2006 and 2012 (a 2.1% increase), while the population aged 65 and above experienced a larger increase, both in absolute (increasing by almost 62,000, from 524,000 to 586,000) and relative terms (11.8%). So both populations have increased in Wales according to recent data, but the population aged 65 and over has risen at a much faster pace.

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1 Laing & Buisson, Care of Elderly People UK Market Survey 2012/13 – press release
Future care needs will depend on various factors, but clearly the number of older people is an important driver behind the demand for care services. In the charts below we show the ONS population projections over the next 25 years for the group aged 65 and above and 85 and above, in absolute terms and relatively to the working age population (16 to 64). While the overall number gives an indication of potential future demand (subject to care needs, which depend on health status), the relative ratios of the groups aged over 65 or over 85 relative to the working age group can provide some general insight into whether changing the relative burden of funding between users and taxpayers may be a viable solution in the medium-long term.

The charts show the population projections on the left vertical axis and the ratio of the group over 65 (or over 85) to the working age population on the right vertical axis. As shown in Figure 2, the number of individuals aged 65 and above in Wales is projected to increase steadily over the next 25 years, from 600,000 in 2013 to almost 900,000 in 2037. The ratio of the group aged 65 and above relative to the working age population is projected to increase at a fast rate over the next 25 years (right vertical axis), growing from 31% in 2013 to around 47% in 2037. According to the projections, by the end of the period considered there will be almost one person aged over 65 in Wales for every two working age individuals.
Corresponding projections for the United Kingdom show that the number of people over 65 is predicted to grow from around 11 million in 2013 to almost 18 million by 2037, while the group of over 85 will grow from 1.5 million in 2013 to 3.6 million in 2037. The relevance of the group of people aged 65 and above and 85 and above compared to the working age group is and will remain higher for Wales than for the rest of the UK. In fact, the ratio over 65/working age population is currently 31% in Wales growing to 47% by the end of the period considered, while it is currently around 27%
for the UK as a whole, growing to 42% by 2037. Similarly, the ratio of over 85 to the working age group is currently at 4% in Wales and predicted to grow to 10% by 2037, while the ratio for the UK will grow from 3.6% in 2013 to 8.6% in 2037.

In Figure 4 and Figure 5 we show projections directly related to future health and care needs and use of social care services for the group aged 65 and above. In Figure 4 we present the projections for the population aged 65 and above unable to manage at least one mobility activity (red line) or one self care activity on their own. The Welsh population aged 65 and above with difficulties in self care activities is projected to grow from slightly less than 200,000 in 2013 to almost 285,000 in 2030 (corresponding to a 43.5% increase), while the over 65 population with mobility difficulties is projected to grow from slightly less than 110,000 in 2013 to almost 160,000 in 2030 (a 47% increase). It should be noted that there may be substantial overlap between the two series given that the same person may be included in both groups.

Figure 4: Health projections for the Welsh population aged 65 and above, 2013-2030

Note: The same person may be recorded in both series. These projections are based on applying existing prevalence rates for those unable to manage mobility and self care activities to future projections of the demographic structure of the population. They do not take account of any potential changes in the prevalence of health problems in the population.

Source: LE Wales using projections published on Daffodil based on results from the 2001 General Household Survey

Figure 5 shows the projections up to 2030 for the number of older users of residential and non-residential social care services in Wales. According to the projections, the number of people aged 65 and above using non-residential care services (community based) will rise from 44,000 to 67,000 (a 53% increase) while the number of older people in residential care will leap from 11,700 to 19,000 between 2013 and 2030 (a 63% increase).

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Both charts are based on information published on Daffodil (http://www.daffodilcymru.org.uk/)
Figure 5: Projections on social care service users in Wales, 2013-2030

Note: Adults receiving services at the 31st March. These projections are based on applying existing prevalence rates for care use to future projections of the demographic structure of the population. They do not take account of any potential changes to the rate at which older people use care services.

Source: LE Wales using projections published on Daffodil based on figures from StatsWales
2 Adult care services in Wales

2.1 Introduction

In this Chapter we use data collected by local authorities and published by StatsWales to present a picture of the number of people who received adult social care services from Welsh local authorities (either directly, or through private or third sector providers where that provision has been funded by Welsh local authorities); of local authority spend on those services; and the revenue that local authorities receive from charges for those services.

These data do not include information about individuals who arrange and fund their care independently of the local authorities. Accurate information about these ‘self-funders’ is not available, though we will seek to make estimates for Wales during the second stage of this work. There may well be a significant number of these self-funders that are not captured in the data presented here. For example, it has been estimated that in England, 43% of individuals staying in care homes were fully self-funded in 2013, and that 19% of non-residential care users were fully self-funded in 2006.

In the remainder of the section, we disaggregate as far as possible the data by type of service, by type of service user, and by local authority. To access this data, which was collected from Welsh local authorities, we used StatsWales, the Welsh Government’s statistics website.

2.2 Number of adult service users

In this section we present a series of charts describing the recent trends in the number of adult social care service users, in total and disaggregated by age (18-64 and 65 plus) and type of service (residential and non-residential services). Unless otherwise specified, the series presented refer to the Welsh total and the number of clients receiving services during the year.

Figure 6 shows the trend between 2006/07 and 2012/13 for the total number of adult service users as a proportion of the adult population, disaggregated by detailed age group: 18-64 and 65 and above, with further disaggregation for the latter age group into three age bands, 65-74, 75-84 and 85+. The number of service users as a proportion of the general population stayed virtually constant for the younger age group (18-64) between 2006/07 and 2012/13, moving from 1.4% to 1.5%. For the group aged 65+, the proportion of service users as a share of the relevant population decreased from 15.3% to 14% in the period considered. As expected, for the group of older people there is significant variation across age bands in the proportion of service users accessing care services: the ratio of service users as a share of the population aged 65-74, 75-84 and 85+ was around 5%, 16% and 48% respectively. Also the share of service users slightly declined in the period for all age groups.

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4 Laing & Buisson, Care of Elderly People UK Market Survey 2012/13 – press release
Figure 6: Adult service users as a proportion of the adult population

Note: Total number of adult clients during the year.
Source: LE Wales’ analysis of StatsWales data

The next chart shows the overall number of service users between 2006/07 and 2012/13 for the groups aged 18-64 and 65 and above (on aggregate). In the older age group (65+), the overall number of service users increased slightly in the period considered, from 80,000 in 2006/07 to 82,200 in 2012/13 (after peaking at 83,000 in 2011/12). Considering the slight decline in the share of service users shown in Figure 6, this means that the number of service users aged 65 and above has risen more slowly than the rise in the population over 65. The number of service users aged 18-64 rose in absolute terms (from 25,800 to 28,700) and, as already shown, remained virtually unchanged as a proportion of the relevant population between 2006/07 and 2012/13.

Figure 7 also shows the share of the total number of adult service users taken up by each age group. The ratio of service users aged between 18 and 64 represented 24.4% of the total in 2006/07 and gradually increased over time, reaching 25.9% in 2011/12 and 2012/13, reflecting the more rapid rise in the number of service users in the younger age group compared to the change in the older age group.
Figure 7: Number of adult service users by age group

The first two charts presented the number of adult service users, disaggregated by age group, but with no disaggregation by type of service. Figure 8 introduces the main disaggregation by type of service (residential and non-residential care services), while further disaggregation is presented in the successive charts. Throughout the section it should be remembered that the total number of service users does not equal the sum of the numbers of clients receiving each individual service, as clients may receive more than one service.

For the group aged 65 and above the number of service users receiving non-residential care services (number of clients supported in the community during the year) rose from 64,100 in 2006/07 to 69,600 in 2011/12 and slightly declined to 68,600 in 2012/13. Conversely, the number of clients in the same age group (65+) receiving residential services declined from 19,000 to 17,300 between 2006/07 and 2012/13. Similarly, in the younger age group (18-64) there was a positive trend in the number of service users receiving non-residential services (increasing from almost 24,000 to nearly 27,000), while the number of users receiving residential services declined from almost 2,500 to slightly more than 2,300 in the period considered.
Residential and non-residential care services can be further disaggregated into the respective component elements, presented in Figure 9 (residential care) and Figure 10 (non-residential) for the group of older people and Figure 11 (residential) and Figure 12 (non-residential) for the group aged 18 to 64.

Users of residential care services can be divided into adults receiving personal care and nursing care in a care home registered to provide nursing care and adults receiving personal care in care homes with no nursing element. The latter group can be further subdivided into users receiving care services in local authority care homes and users receiving care services in independent sector care homes under contract. Figure 9 shows the number and breakdown of users receiving residential care for the group aged 65 plus between 2006/07 and 2012/13. As already mentioned, the overall number declined during the period and the drop was mainly driven by a decline in the numbers receiving residential care directly through local authority care homes (from 4,000 in 2006/07 to around 2,600 in 2012/13). The fall in the number of users receiving residential services in local authority care homes was only partially balanced by the rise in the numbers receiving services in care homes under contract (from 8,850 to 9,250), so that the total number of residential placements in care homes for users aged over 65 (with no nursing component) declined from 12,850 to 11,800 in the period considered. The number of older people treated in nursing care homes also declined in the period, falling from 7,000 in 2006/07 to 6,250 in 2012/13.

Figure 10 shows the breakdown of the number of service users over 65 by type of non-residential service received. The main non-residential services are home care (standing at around 33,000 in 2006/07 before declining to just above 31,000 in 2008/09 and reaching again 33,000 users in 2012/13), equipment (leaping from 23,000 users to 33,000 users between 2006/07 and 2012/13), adaptations (increasing from 10,300 to around 12,000), meals (declining from 12,000 to less than 8,000) and day care (decreasing from 10,200 to 7,600). The number of older people receiving reablement services increased dramatically during the period leaping from 2,200 to 9,600.
Figure 9: Number of residential care service users aged 65+

Note: Number of adult clients during the year. The total number of clients does not equal the sum of numbers of clients receiving the different services, as clients may receive more than one service.

Source: LE Wales' analysis of StatsWales data

Figure 10: Number of non-residential care service users aged 65+

Note: Number of adult clients during the year. The total number of clients does not equal the sum of numbers of clients receiving the different services, as clients may receive more than one service.

Source: LE Wales' analysis of StatsWales data
Figure 11 and Figure 12 present the breakdown over time for residential and non-residential services received by users aged between 18 and 64. For this group the number of people receiving residential services is much smaller compared to the older age group, but the trend over time is similar: the number of people in local authority care homes more than halved in the period (from 202 to 99), while the number of people receiving contracted-out residential care services slightly increased (from 1,839 to 1,846). Also, there was a decline in the number of service users receiving nursing care, from 577 to 412.

When comparing non-residential services across age groups, some noticeable differences in the relevance of different services received can be identified. As shown in Figure 12, equipment is the largest category for individuals aged 18-64 with a rapid increase from 7,450 to 9,500 between 2006/07 and 2012/13; the number of users receiving adaptations also increased in the period, rising from 4,200 to 4,500 users. Home care users slightly declined from 7,600 to 7,300, while the number of people attending day care centres dropped by 1,000 in the period considered (from 7,000 to about 6,000). Community support day care, direct payments and respite care are relatively important for this age group and fast-growing: the number of users receiving community support day care increased from 2,500 to 3,800, the number in receipt of direct payments rose from 1,150 to 2,800 and the number of people receiving respite care moved from 2,000 to 2,400 between 2006/07 to 2012/13.
Figure 12: Number of non-residential care service users aged 18-64

![Diagram showing number of non-residential care service users aged 18-64 over years 2006-2013]

Note: Number of adult clients during the year. The total number of clients does not equal the sum of numbers of clients receiving the different services, as clients may receive more than one service.

Source: LE Wales' analysis of StatsWales data

2.2.1 Number of adults assessed during the year

Statistics collected from the local authorities and published by StatsWales also report the number of individuals applying for and receiving an assessment by local authorities during the year. The series refers to the total number of adults with no breakdown by age group. The trend over time can provide some evidence on whether the number of individuals receiving assessment changed significantly after the introduction in April 2011 of the £50 weekly cap on charges for non-residential care services. While charges for individual services are based on the financial assessment, the weekly cap on charges is applied irrespectively of income and assets held. Recent anecdotal evidence from local authorities suggests that an increasing number of individuals are declining to provide financial information as part of the assessment process, being aware that they would pay the weekly maximum charge irrespective of the financial assessment. It is also possible that a number of people who would have purchased care services privately in the absence of the cap (not engaging at all with the local authority) are now going through the needs assessment, but declining to report their financial details. It should also be remembered that the cap on charges was set by the Welsh Government and applies to all local authorities.

The number of adults being assessed during the year increased significantly between 2006/07 and 2008/09, leaping from 79,600 to 90,750, before sharply declining to 82,950 by 2010/11. The last two years have seen a strong recovery in the number of people being assessed, with an increase to 87,000 adults in 2012/13. Clearly, it is difficult to determine exactly whether the large fall in 2010/11 and the recovery afterwards were mainly driven by the introduction of the cap or by other factors.

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Information provided by the Welsh Government
22

2.2.2 Distribution of hours of homecare services provided

Figure 14 presents the trend over time of the average number and distribution of the hours of homecare provided during the last week of September. The grey line shows the average number of hours of homecare provided (right axis), while the stacked columns display the proportion of adult clients taken up by each category (less than 5 client hours, 5-9 hours, 10-19 hours, 20 or more). The series refer to the aggregate for adult clients in Wales. The distribution of hours of homecare provided to clients clearly shows a shift over time, with the category recording the mildest treatment intensity (up to 5 client hours) losing importance over time (from 42% to 35% between 2006/07 and 2012/13) and the category 10-19 hours significantly rising in relevance (from 21% to 28%). The proportion taken up by the other two categories (5-9 hours and 20 or more) was virtually unchanged. This shift in treatment intensity is also reflected by the average number of hours of homecare provided, which was standing at around 8.5 hours per client in 2006/07 and had increased to 10.3 hours per client by 2012/13.
Figure 14: Distribution of hours of homecare provided during the last full week in September

Note: Distribution and average number of hours of homecare provided to adult clients in the last full week in September. The average was computed using the series on the total number of clients receiving homecare and the number of hours of homecare provided to clients.

Source: LE Wales' analysis of StatsWales data

2.2.3 Breakdown of services provided by Local Authority in 2012/13

The analysis presented so far in this section has focused on the characteristics of adult service users and services received at the national level. The charts displayed in Figure 15 to Figure 17 present the breakdown of service users for the 22 Welsh local authorities using data from the latest available year (2012/13).

Figure 15 shows the relative importance of residential and non-residential services provided by each local authority. As already mentioned, the total of residential and non-residential users is higher than the total number of clients receiving social care services during the year, as clients may receive more than one service. The information displayed in Figure 15 can be used to identify local authorities with a relatively high (low) number of clients using residential (non-residential) services compared to the average for Wales.

On average for Wales, for 100 adult service users, 17 are receiving residential care services and 83 are in receipt of non-residential care services (the total includes double counting for users receiving both types of service in a given year). Across local authorities the ratio varies from 26/74 in Gwynedd to 11/89 in the Pembrokeshire area. More specifically, Gwynedd, Isle of Anglesey, Carmarthenshire and the Vale of Glamorgan seem to have a relatively high ratio of clients receiving residential care services (more than 20 every service 100 users), while the opposite is true for Torfaen, Blaenau Gwent, Caerphilly and Pembrokeshire (around 11 per 100 service users).
The number of adult service users (18+) receiving different types of residential services (residential care and residential care with nursing care) is shown in Figure 16. As in Figure 11, total residential placements in care homes are split into the number of adults in local authority care homes and the number in independent sector care homes under contract. The highest number of adults receiving services was recorded in Rhondda Cynon Taf in 2012/13, followed by Swansea and Cardiff. Interestingly, four local authorities (Cardiff, Neath Port Talbot, Powys, Torfaen) decided not to provide any residential care service directly and to rely solely on contracted-out care homes, with a further three LAs (Wrexham, Conwy and Pembrokeshire) only providing residential care services through local authority care homes to a very limited number of clients. Conversely, residential care services provided through local authority care homes covered a substantial share of total residential placements for some local authorities (for example Carmarthenshire, Gwynedd and Ceredigion).

Note: Number of adult clients during the year. The red dashed line identifies the residential/non-residential split for Wales. The total number of clients does not equal the sum of numbers of clients receiving the different services, as clients may receive more than one service.

Source: LE Wales’ analysis of StatsWales data

It should be remembered that the same client may receive more than one service.
Figure 16: Number of adults receiving residential services by LA, 2012-13

Note: Number of adult clients during the year. The total number of clients does not equal the sum of numbers of clients receiving the different services, as clients may receive more than one service. 
Source: LE Wales’ analysis of StatsWales data

Finally, Figure 17 displays the type of non-residential care services received by adult clients in each Welsh local authority in 2012/13. Rhondda Cynon Taf and Cardiff are the local authorities with the highest number of non-residential service users, followed by Caerphilly and Swansea. Interestingly, Caerphilly is ranked third for non-residential services provided, but only seventh for residential services. As can be seen in the chart, there is significant variation across local authorities: for example Swansea has a high number of clients receiving day care services compared to other local authorities with a similar total number of clients during the year, Cardiff has large number of clients receiving home care services and both Caerphilly and Cardiff have a high number of clients receiving equipment. The most significant variation probably relates to reablement services provided by local authorities: five LAs (Neath Port Talbot, Ceredigion, Caerphilly, Carmarthenshire and Rhondda Cynon Taf) provide reablement services to more than 1,000 adult clients (with Neath Port Talbot in excess of 2,000 clients), while four other local authorities reported no provision of reablement services in 2012/13 (Vale of Glamorgan, Cardiff, Merthyr Tydfil, Torfaen) and a further local authority (Flintshire) only provided reablement services to one client. A similar variation can be observed for the number of clients receiving meals during the year and, to a lesser extent, adaptations.
2.3 Expenditure on and income from adult care services

In the previous section, we showed different breakdowns of the type and number of clients receiving services. In this section we introduce aggregate and disaggregated series on gross expenditure (total spending on social care services by local authorities) and income from fees, sales and charges (the part of gross expenditure covered by charges to clients). All series are expressed in real terms, i.e. adjusted to remove the effects of general price inflation, and refer to the total for Wales, unless otherwise specified.

2.3.1 Gross weekly expenditure per adult service user

Figure 18 shows total annual adult gross expenditure on social care services (right axis) and total annual adult gross expenditure as a proportion of the Welsh GDP (left axis). Overall, real gross expenditure increased from around £1,330 million to £1,400 million between 2006/07 and 2009/10 before declining to around £1,325m in 2011/12 and 2012/13. Expressed as a proportion of the Welsh GDP, gross expenditure stood at 2.6% of total GDP in 2006/07, increased to 2.9% by 2009/10 and slightly declined to 2.8% in 2010/11 and 2012/13.

In Figure 19 we present total annual gross expenditure disaggregated by age group (65+ and 18-64). The trend for the two age groups slightly diverged over time: both series followed a similar trend peaking in 2009/10 (£737m for older service users vs. £666m for younger adult service users), before declining. However, gross annual expenditure for the older age group in 2012/13 was significantly below the value at the beginning of the period (£701m compared to £728 in 2006/07), while the opposite is true for the younger age group (£623 vs. £601 in 2006/07).
In Figure 20 we present gross weekly expenditure per adult service user, disaggregated by age group (65+ and 18-64) and by type of expenditure (expenditure on residential\(^8\) and non-residential services\(^9\)).

\(^8\) Residential gross expenditure and income per client were calculated using the sum of expenditure (income) on personal care in nursing home placements and residential care placements divided by the total number of clients receiving residential care services.

\(^9\) Non-residential gross expenditure and income per client were calculated using the sum of expenditure (income) on direct payments, home care, day care, equipment and adaptations, meals, and other services to older people divided by the total number of clients supported in the community during the year.
and supported and other accommodation\textsuperscript{10}). As shown in the chart there is substantial variation in average gross expenditure per user both across age groups and expenditure items. For the older age group (65+) average gross weekly expenditure per user was around £164 in 2012/13, down from £175 in 2006/07, average residential expenditure stood at £400 in 2012/13 (up from £386 in 2006/07), average expenditure on non-residential services was £75 in 2012/13, decreasing from £81 in 2006/07 and average expenditure on supported and other accommodation was around £321 in 2012/13 and exhibit significant variation in the period.

In contrast, average weekly gross expenditure for the younger age group (18-64) stood at around £417 in 2012/13 (significantly down from £447 in 2006/07) and was substantially higher compared to gross expenditure per user in the older age group. Gross average weekly expenditure in 2012/13 was around £1,280 for residential services (up from £1,190 in 2006/07), £198 for non-residential services (down from £210 at the beginning of the period) and £837 for supported and other accommodation (significantly decreasing from £1,066 in 2006/07). The ratio of average gross expenditure for the younger age group was around 3 times as large as the average expenditure for the older age group.

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure20}
\caption{Gross average weekly expenditure per adult service user}
\end{figure}

\textbf{Figure 20: Gross average weekly expenditure per adult service user}

Note: Real gross expenditure expressed in 2012/13 values.
Source: LE Wales’ analysis of StatsWales data

In the next charts we present weekly average expenditure disaggregated by specific type of service (as usual grouped into residential and non-residential services) and age group (65+ and 18+). Figure 21 provides the detail for residential services to individuals aged 65 and above. Gross average expenditure on residential care and nursing placements followed a roughly similar trend in the period considered, although gross expenditure on nursing placements was relatively flatter and on average around £100 less than the average weekly expenditure on residential care placements. Gross expenditure on nursing care excludes the weekly contribution towards nursing care (currently

\textsuperscript{10} Expenditure on Assessment and care management is part of total expenditure, but not presented here
£120.56 in most local authorities) made by local health boards (LHBs) and any expenditure by LHBs on ‘Continuing Health Care’ for those with higher medical needs.

**Figure 21:** Gross average weekly expenditure on residential services per adult service user, 65+

![Graph showing weekly expenditure on residential services per adult service user, 65+](image)

*Note: Real gross expenditure expressed in 2012/13 values. Expenditure on nursing placements refers to the personal care element only and excludes the contribution by the Local Health Board.*

*Source: LE Wales’ analysis of StatsWales data*

**Figure 22:** Gross average weekly expenditure on non-residential services per adult service user, 65+

![Graph showing weekly expenditure on non-residential services per adult service user, 65+](image)

*Note: Real gross expenditure expressed in 2012/13 values. For some non-residential services it was not possible to determine figures on gross expenditure per service user.*

*Source: LE Wales’ analysis of StatsWales data*
Figure 22 shows average expenditure for non-residential services provided to older adults. Expenditure on direct payments had the highest average in the period, but significantly declining from £200 to £150, followed by home care (in the range of £110-£130) and day care services (stable around £55 for much of the period before leaping to £80 in 2012/13). Gross expenditure on meals per adult service user rose slightly in the period, moving from £17 to £24.

Figure 23 and Figure 24 present the equivalent data series (gross expenditure on residential and non-residential services per adult service user) for the group of clients aged between 18 and 64.

The trend over time for average expenditure on residential care placements and nursing care placements is similar, peaking in 2009/10 then declining and rising slightly in 2012/13. Over time the gap between the two series moves around £500, with average weekly expenditure on residential care placements standing at about £1,345 in 2012/13 compared to approximately £845 for nursing care placements.

Turning to the analysis of gross expenditure on non-residential care services for younger adults (Figure 24), expenditure on day care services has the highest average, rapidly rising in the period (from less than £250 to around £300), while average expenditure on both direct payments and home care moves around the £200 mark. Finally, expenditure on meals per service user moves between £15 and £22 before declining to £11 in the last two years of the period.

Figure 23: Gross average weekly expenditure on residential services per adult service user, 18-64

Note: Real gross expenditure expressed in 2012/13 values. Expenditure on nursing placements refers to the personal care element only and excludes the contribution by the Local Health Board.

*Source: LE Wales’ analysis of StatsWales data*
2.3.2 Total gross expenditure by expenditure item

In the next charts, we show the distribution of total gross expenditure by expenditure item for total adult services and non-residential services for 2012/13. Figure 25 presents the distribution of gross expenditure for older people (65+): total gross expenditure in 2012/13 was approximately £700M and more than 50% of the total was taken up by expenditure on residential services, with non-residential services covering 38% of the total, followed by assessment and care management (9%) and supported and other accommodation (2%). Looking at non-residential services provided to older adults, expenditure on home care took up more than two thirds of the total in 2012/13, followed by day care services (12%) and other services to older people (8%).

Source: LE Wales' analysis of StatsWales data
Figure 26 displays the equivalent pie charts for adult service users aged 18-64 and the picture is much more varied: looking at total expenditure (around £623m), non-residential expenditure had the relative largest share (44%), followed by expenditure on residential services (25%) and supported and other accommodation (20%). The largest expenditure item for non-residential services to younger adults in 2012/13 was day care (one third of the total), followed by home care (27%) and other services to older people (25%).

![Figure 26: Gross expenditure on adult services by expenditure item in 2012/13, 65+](image)

**Note:**
*Source: LE Wales’ analysis of StatsWales data*

### 2.3.3 Local Authority income from fees, sales and charges

Local authority income from fees, sales and charges represents the part of their gross expenditure recovered through the contribution of service users. Figure 27 shows the trend for total weekly income per adult service user and the main income components over time. The older age group pays more on average than the younger age group (£32 vs. £25 in 2012/13). The average user contribution for the different components of care services is also higher for each of the components analysed (residential, non-residential and supported and other accommodation).

On average, older adult service users pay higher charges and receive less expenditure, so we would expect the share of total gross expenditure covered by income from clients to be much higher for the group aged over 65. In 2012/13 total income recovered from fees, sales and charges was around £136m for the group of clients aged 65 and above (corresponding to 19% of gross expenditure) and about £37m (6% of gross expenditure) for the group aged between 18 and 64. Overall, income from fees, sales and charges was approximately £173m in 2012/13, corresponding to 13% of gross expenditure on adult care services.

The contrast is particularly striking for residential care services: for older adults approximately 30% of total gross expenditure on residential care services is covered by income from clients, while the proportion drops to 7% for younger adults. For non-residential services, the share of gross expenditure covered by income from clients in the period considered (2006/07 to 2012/13) was between 10% and 13% for older adults and between 6% and 8.5% for the group aged 18 to 64 (with both series showing a declining trend over time).
Figure 27: Weekly average income from sales, fees and charges per adult service user

Note: Real gross expenditure expressed in 2012/13 values.
Source: LE Wales’ analysis of StatsWales data

Figure 28: Income as a proportion of gross expenditure

Note: Real gross expenditure expressed in 2012/13 values.
Source: LE Wales’ analysis of StatsWales data
Figure 29 and Figure 30 show the detail of the share of non-residential expenditure covered by income from users by age group: for both groups, meals is the only item for which a substantial share of gross expenditure (up to 40%) is covered by income from clients. Curiously, the series for equipment and adaptations show a striking spike in 2008/09 and 2009/10 before declining again.\textsuperscript{11}

\textbf{Figure 29: Income as a proportion of gross expenditure on non-residential services, 65+}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure29}
\caption{Income as a proportion of gross expenditure on non-residential services, 65+}
\end{figure}

Source: LE Wales' analysis of StatsWales data

\textbf{Figure 30: Income as a proportion of gross expenditure on non-residential services, 18-64}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure30}
\caption{Income as a proportion of gross expenditure on non-residential services, 18-64}
\end{figure}

Source: LE Wales' analysis of StatsWales data

\textsuperscript{11} We understand that this may, in part, be the result of a three year capital expenditure programme by one local authority that lead to a reduction in operating costs over the same period.
Next, we compare total gross expenditure and total income from adult clients in 2012/13. The group of older people covers 78% of total income, but only receive 53% of total gross expenditure. In stark contrast, the different groups of younger adults disaggregated by type of need (physical disability, learning disabilities and mental health needs) contributes to 7%, 10% and 3% of total income respectively, while receiving 9%, 28% and 7% of total gross expenditure.

![Figure 31: Gross expenditure and income from fees, sales and charges by client type, 2012/13](image)

Source: LE Wales' analysis of StatsWales data

### 2.3.4 Expenditure and income data from Local Authorities, 2012-13

Finally, we present gross weekly expenditure per adult service user and the proportion of gross expenditure covered by income from clients by local authority. Both series refer to the year 2012/13.

![Figure 32: Gross average weekly expenditure per adult service user by LA, 2012/13](image)

Note: Gross weekly expenditure per adult service user (18+)

Source: LE Wales' analysis of StatsWales data
Figure 32 shows gross average weekly expenditure per adult service user by type of service (residential and non-residential) in 2012/13. At the Welsh level average expenditure per residential user is around £500 compared to £100 per non-residential user. However, there is significant variation across local authorities with average weekly expenditure per residential service user varying between £660 in Blaenau Gwent and £341 in Cardiff. Most other local authorities have average weekly expenditure per residential service user in the range £430-£590, apart from two other local authorities with average weekly expenditure in excess of £600 and one LA spending less than £400. Conversely, Cardiff has the highest average weekly expenditure per non-residential service user, at around £176 per week, while all other LAs have an average expenditure on non-residential services in the range £69-£110 per week.

Figure 33 shows the proportion of total gross expenditure recovered from income from clients in 2012/13. Isle of Anglesey recovered almost 43% of total adult gross expenditure on residential services, followed by Torfaen, Gwynedd and Rhondda Cynon Taf (all recovering more than 30% of expenditure on residential services from income from clients). At the other end of the spectrum, Flintshire and Denbighshire recovered only around 5% of expenditure on residential services from income from clients. Isle of Anglesey and Rhondda Cynon Taf also had the highest ratios of gross expenditure on non-residential services covered by income from clients (both around 20.5%), while Newport and Denbighshire only recovered less than 4% of total expenditure on non-residential services from income from clients.

According to data submitted by local authorities to StatsWales in 2012/13, Merthyr Tydfil was recovering a negligible amount of gross expenditure from income from clients.

Note: Gross expenditure and income from clients for all adult service users (18+)

Source: LE Wales' analysis of StatsWales data
### 3 Charging for care by Welsh Local Authorities

The main distinction between care services is whether they are received in the community (non-residential care services) or in a residential care home (residential care services). The first type of care services are provided to people still living at home and include home care services, attendance to a day care centre, night-sitting services, reablement services, equipment and adaptations and ancillary services such as meals (at home or in a day centre) laundry and transport to day centres. Residential care services are provided to individuals assessed as not being able to live in their home and in need of moving to a care home. When nursing care is also needed, individuals will move to a nursing care home. Costs for people living in residential care can be divided into care costs (and nursing costs when needed) and living and accommodation costs.

Local authorities have a duty to provide or arrange care services to people in need. However, support by local authority is subject to an assessment process, divided into:

- **A needs assessment** to assess the individual level of need, whether that meets the local authority’s eligibility criteria and the package of care services needed;
- For individuals considered to be in need of care, a **financial assessment** is then undertaken to work out how much the individual can contribute towards the cost of care services. Some form of income and assets are not taken into account (i.e. disregarded) in the financial assessment and there is a minimum level of allowance each user is guaranteed to be left with after paying for care services.

#### Needs assessment

Access to care services provided by local authorities is subject to a needs assessment. Individuals are assessed on a four point scale according to the increasing level of need: low, moderate, substantial and critical. While local authorities have discretionary power in setting the level of need required to access LA funded services, limited resources means that most local authorities currently focus their support on individuals with critical or substantial needs. In fact, 17 out of 22 Welsh local authorities currently set the eligibility threshold at substantial, a further four local authorities at moderate and one local authority at low level of need\(^{12}\). Under the forthcoming Social Services and Well-being (Wales) Act, a national eligibility framework is planned, ensuring consistency in needs assessment across all Welsh local authorities\(^{13}\).

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\(^{12}\) The Welsh Government recently published a new guidance (see the “Integrated Assessment, Planning and Review Arrangements for Older People”; Welsh Government, December 2013) setting out the responsibilities of health and social care professionals in supporting people who are aged 65 years and above. The guidance restated that “the four bands range from critical and substantial, to moderate and low” and “it will be for individual local authorities to draw the line of eligibility within the framework according to their local circumstances”(Annex G).

### Table 1: Eligibility threshold for care services in Welsh local authorities

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Eligibility Threshold (as known at January 2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isle of Anglesey</td>
<td>Critical, Substantial</td>
</tr>
<tr>
<td>Gwynedd</td>
<td>Critical, Substantial</td>
</tr>
<tr>
<td>Conwy</td>
<td>Critical, Substantial</td>
</tr>
<tr>
<td>Denbighshire</td>
<td>Critical, Substantial</td>
</tr>
<tr>
<td>Flintshire</td>
<td>Critical, Substantial</td>
</tr>
<tr>
<td>Wrexham</td>
<td>Critical, Substantial</td>
</tr>
<tr>
<td>Powys</td>
<td>Critical, Substantial, Moderate</td>
</tr>
<tr>
<td>Ceredigion</td>
<td>Critical, Substantial</td>
</tr>
<tr>
<td>Pembrokeshire</td>
<td>Critical, Substantial</td>
</tr>
<tr>
<td>Carmarthenshire</td>
<td>Critical, Substantial</td>
</tr>
<tr>
<td>Swansea</td>
<td>Critical, Substantial</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>Critical, Substantial</td>
</tr>
<tr>
<td>Bridgend</td>
<td>Critical, Substantial, Moderate</td>
</tr>
<tr>
<td>Vale of Glamorgan</td>
<td>Critical, Substantial</td>
</tr>
<tr>
<td>Cardiff</td>
<td>Critical, Substantial</td>
</tr>
<tr>
<td>Rhondda Cynon Taf</td>
<td>Critical, Substantial, Moderate, Low</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>Critical, Substantial</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>Critical, Substantial, Moderate</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>Critical, Substantial</td>
</tr>
<tr>
<td>Torfaen</td>
<td>Critical, Substantial</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>Critical, Substantial, Moderate</td>
</tr>
<tr>
<td>Newport</td>
<td>Critical, Substantial</td>
</tr>
</tbody>
</table>

*Source: Welsh Government*

### Financial assessment

The next step in the assessment process is to work out how much users need to contribute towards the costs of the package of care they receive. Charges for care services depend on the type and complexity of services received (e.g. hours of home care, visits to a day centre) and on service users’ capacity to contribute towards the cost of care. Local authorities have a degree of discretion in setting charges and disregards, but some services need to be provided free of charge and some income and asset components need to be disregarded according to national regulations.

Also, charges, income disregards and the minimum weekly allowance vary according to whether the client is receiving non-residential or residential care services.

In the following sections we present the charging structure and income and assets disregards applied in each local authority for the provision of non-residential and residential care services.

The information presented was originally gathered searching documentation publicly available on local authorities’ websites. We then asked each Welsh local authority to confirm that the information collated online was correct and up to date (for 2013/14), or to provide the level of charges and income disregards for the 2013/14 financial year and, when possible, for the new financial year (2014/15). Overall 19 out of 22 local authorities responded to the survey providing information on non-residential care charges and income disregards and residential fee contributions and income
disregards. For the remaining three local authorities we used, when possible, information gathered on their websites. All information presented refers to the financial year 2013/14, unless otherwise stated.

3.1 Charging for non-residential care services

Income disregards

According to national regulations on non-residential care services, certain types of income and savings are disregarded in the financial assessment and local authorities need to ensure that users are left with a minimum weekly income equal to the basic level of Income Support, Employment and Support Allowance or and guarantee credit (varying with age and disability status) plus 35% and a further 10% allowance for disability-related expenditure.

The main items disregarded in the financial assessment according to current national guidelines are:

- Employment earnings of service user (net of any Income Tax and National Insurance contributions) and the associated Working Tax Credit;
- The Mobility Component of Disability Living Allowance (DLA) or Personal Independence Payment (PIP);
- Any mortgage, rent or Council Tax payments;
- Savings Credit element of Pension Credit;
- £10 of War Disablement Pension\(^{14}\) and War Widows Pension\(^{15}\);
- 100% of other War-related pensions (e.g. War Pensioner’s Mobility Supplement, Armed Forces Independence Payment – mobility component and guaranteed income payment, War Widows Supplementary Pension);
- 100% of special circumstance allowances (e.g. Vaccine damage payment, Skipton Fund/MacFarlane Trust payment); and certain payments made under the Armed Forces and Reserve Forces (Compensation) Order 2011

Local authorities have then the discretion to disregard other types of income and savings. We have collected information on further income and assets disregards through a survey of local authorities and information published on their websites. From the survey it emerged that the following types of income and assets are always fully taken into account by local authorities in the financial assessment:

- Guarantee Credit element of Pension credit;
- all annuities\(^{16}\);
- savings and investments without a life cover component beyond the capital limit threshold (£23,750 in 2013/14 and £24,000 in 2014/15);
- State and occupational/private pension; and

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\(^{14}\) With exception of the local authorities of Conwy, Denbighshire, Gwynedd, Monmouthshire, Swansea, Torfaen and Wrexham, which reported a full disregard for the War Disablement Pension.

\(^{15}\) With exception of the local authorities of Conwy, Gwynedd, Monmouthshire, Swansea, Torfaen and Wrexham, which reported a full disregard for the War Widow’s Pension.

\(^{16}\) With the exception of Swansea, where annuities are fully disregarded in the non-residential care financial assessment in 2013/14. In Caerphilly annuities were fully disregarded in the non-residential care financial assessment in 2013/14 but will no longer be disregarded in 2014/15
Employment Support Allowance\(^1\), Job Seekers Allowance, Severe Disablement Allowance, Incapacity Benefits, Invalid Care Allowance\(^2\), the care component of PIP and other state benefits.

Other types of income and savings may be partially or fully disregarded depending on each local authority’s decision. Below we present a summary table with relevant information gathered from local authorities on further income and assets disregards.

\(^1\) With the exception of Gwynedd local authority, where ESA is 100% disregarded
\(^2\) With the exception of Newport, where the Invalid care Allowance is 100% disregarded.
### Table 2: Income disregards for non-residential care services across Welsh local authorities

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Trust funds (to which the user has absolute entitlement)</th>
<th>Attendance Allowance (A.A) (up to middle rate)</th>
<th>Disability Living Allowance (D.L.A) (up to middle rate)</th>
<th>Difference between the Higher Rate and Middle Rate of AA and DLA unless a night time service is provided (currently £26.15)</th>
<th>Disabled Person's Tax Credit</th>
<th>Carer's Allowance</th>
<th>Winter Fuel Payments</th>
<th>Christmas bonuses</th>
<th>Earnings of partner</th>
<th>Partner's Occupational Pension</th>
<th>DLA/AA of partner</th>
<th>Partner's income/savings</th>
<th>Child Benefit</th>
<th>Family Tax Credit</th>
<th>Housing Benefit</th>
<th>Council Tax Benefit</th>
<th>Property (other than main residence)</th>
<th>Year the information refers to</th>
</tr>
</thead>
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Source: LE Wales based on a survey of Welsh local authorities and information published on local authorities’ websites
**Standard level of charges**

Local authorities have a high degree of discretion in the level of charges applied for non-residential care services. According to national regulations the only services they need to provide free of charge are:

- Transport to and from a day centre, where this forms part of their care need assessment;
- Aftercare Services provided under Section 117 of the 1983 Mental Health Act;
- Services provided to sufferers of Creuzfeldt Jacob Disease;
- Intermediate care services (reablement services) for 6 weeks following a stay in hospital;

For all other services provided local authorities have discretion in setting the level of care charges. To provide consistency across the country, the Welsh Government introduced in April 2011 a maximum weekly charge for users in receipt of non-residential care services. The maximum weekly charge was set at £50 in April 2011 and remained at that level for the following three years before increasing to £55 in April 2014. A further rise to £60 has been announced for April 2015.

As shown in Table 3, the level of charges is still significantly different across different local authorities. However, the presence of a maximum weekly charge ensures that users of non-residential care services in Wales will not have to pay a weekly charge beyond a set level. Services incurring a flat charge, such as meals and laundry services are charged for outside the maximum weekly charge.

The following caveats should be considered when looking at the information gathered by local authorities and presented in Table 3:

- Service provision may be slightly different across local authorities so some charges may not refer exactly to the same type of provision. For example some local authorities reported different rates for Direct Payments depending on whether home care was privately arranged (employing directly) or provided by an agency;
- Charges for Lifeline services are presented under Telecare services, given that they are not typically available separately;
- Some local authorities may also charge a one-off fee for the installation of equipment and adaptations (not shown below);
- In Table 3 we only used rates referring to the standard time unit (e.g. hourly rates for home care);
- When a different rate depending on the level of assets was applied we used the lower rate (e.g. for those having assets below £23,750);
- When two rates were provided for Direct payments we used the rate for privately arranged home care services;
- In other cases where multiple rates were available we typically used the lower rate (when two values or a range were available) or the middle rate (when more than two values were provided);
- Only three responding local authorities were providing laundry services in 2013/14 with charges of £2.20, £3.50 and £5.00 per wash;
- Only information referring to the financial year 2013/14 was used;
Table 3: Summary of charges on non-residential care services across Welsh local authorities in 2013/14

<table>
<thead>
<tr>
<th>Service</th>
<th>Minimum (per day)</th>
<th>Minimum (per hour)</th>
<th>Median (per day)</th>
<th>Median (per hour)</th>
<th>Maximum (per day)</th>
<th>Maximum (per hour)</th>
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<td>Day care</td>
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<td>£6.67</td>
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<td>Home Care purchased by the Authority directly</td>
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<td>£16.00</td>
<td>£13.17</td>
<td>£46.70</td>
<td>£12.17</td>
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<td>Home Care through the Direct Payment Scheme</td>
<td>£6.67</td>
<td>£10.13</td>
<td>£20.84</td>
<td>£12.17</td>
<td>£58.00</td>
<td>£15.72</td>
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<td>Home Care- Night Time Hours</td>
<td>£6.67</td>
<td>£10.40</td>
<td>£20.84</td>
<td>£12.05</td>
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<td>Home Care- Night Time Sleep In</td>
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<td>Supported Accommodation</td>
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<td>Meals at Day Care centre</td>
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<tr>
<td>Meals on Wheels</td>
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Note: N denotes the total number of local authorities providing information on charges for each service. The median identifies the value lying at the midpoint of the frequency distribution of observed values, such that there is an equal number of values above and below it. Service provision may be slightly different across local authorities and some LAs do not provide all services. Only 3 out of 19 responding LAs were providing Laundry Services in 2013/14 (with charges of £2.20, £3.50 and £5.00 per wash)

Source: LE Wales based on a survey of Welsh local authorities

3.2 Charging for residential care services

Income and assets disregards

Individuals in need of moving to a care home are subject to a financial assessment to determine whether they are eligible for public support. The types of income and assets taken fully into account are somewhat different to those considered in the financial assessment for non-residential care services. Crucially, the value of the home the individual has been living in before moving to residential care is only disregarded for the first 12 weeks unless it is the home of another person as deemed eligible within the charging rules. In these circumstances the property is fully disregarded. Thus we can distinguish between the following three situations for individuals moving to a residential care home:

- Individuals with less than £23,750 (£24,000 from April 2014) in all savings and assets (including property) are eligible for public support and none of their asset will be taken into account in the financial assessment. They will be asked to contribute towards the cost of care based on their weekly income, subject to a minimum guaranteed income (Personal Expenses Allowance) of £24.50 per week (£25 from April 2014).

- Individuals with less than £23,750 (£24,000 from April 2014) in non-housing assets, but owning a property (or a share of it) worth more than the capital threshold are eligible for public support but the value of their home will only be disregarded for the first 12 weeks. After that they will be required to pay in full the residential care fees.

- Individuals with more than £23,750 (£24,000 from April 2014) in non-housing assets are not eligible for public support and need to self-fund their own care (however, local authorities still have the duty to make care arrangements for them in certain circumstances if they are unable to do so).

Self-funders can ask to have their financial situation re-assessed if their savings are depleted over time and consequently fall below the capital threshold.

When assessing income and other (non-housing) assets a number of items are permanently disregarded due to national guidelines examples include:
Child Tax Credit;
Guardian’s Allowance;
Christmas bonus;
Council Tax Benefit;
Disability Living Allowance (Mobility Component) and Mobility supplement;
Dependency increases paid with certain benefits;
Social Fund payments (including winter fuel payments); War widows’ special payments.
100% of special circumstance allowances (e.g. Vaccine damage payment, Skipton Fund/ MacFarlane Trust payment); and
Earnings (either via employment or self-employment);
Certain payments made under the Armed Forces and Reserve Forces (Compensation) Order 2011;

The following are examples of items which are never disregarded by local authorities according to the information collected in the survey (unless otherwise stated):

- Rent\(^{19}\) and mortgage\(^{20}\) payments;
- Income support;
- Annuities;
- State and occupational/private pension\(^{21}\);
- The care components of the Attendance Allowance and the Disability Living Allowance while they are still received (unless for respite care, where these are fully disregarded);
- Carer’s Allowance and Invalid Care Allowance; and
- Employment Support Allowance, Job Seekers Allowance, Severe Disablement Allowance, Incapacity Benefits and other state benefits

**Local Authority contribution to care fees**

Local authorities set annually the maximum contribution they will pay to independent care homes providing residential care services and the fees for local authority care homes. The fees cover both care and living accommodation costs in residential care homes. The fee level varies according to residents’ type of need and services provided by care homes. For example, care services for Very Dependent Elderly and Elderly Mentally Infirm are paid a higher contribution. For individuals receiving nursing care services the Local Health Board provides a contribution towards the costs, which is currently set at £120.56 per week across most Welsh health boards. Residents in residential and nursing care homes are then required to contribute to the weekly fee based on their income.

Summary information on fees are presented in Table 4 disaggregated into residential care (with different fees for standard residential care, care for Very Dependent Elderly and Elderly Mentally Infirm) and nursing care (divided into standard nursing care and nursing care for Elderly Mentally

\(^{19}\) With the exception of Wrexham Council, where rent payments are fully disregarded, and Caerphilly, where there could be a discretionary disregard.

\(^{20}\) With the exception of the Newport and Wrexham local councils, where the interest on mortgage payments is fully disregarded, and Blaenau Gwent and Caerphilly, where there could be a discretionary disregard.

\(^{21}\) Unless a couple’s assessment is performed, in which case up to 50% of the occupational/private pension could be disregarded.
Charging for care by Welsh Local Authorities

Infirm). Nursing fees are reported net of the local health contribution. All figures refer to the financial year 2013/14 and are calculated based on responding local authorities.

The information presented in Table 4 provides one indicator of the cost of provision for different types of residential and nursing care services. Combined with information about care home fees, it would also provide an indication of how much residents may need to top up the local authority contribution where they choose to live in a care home that has higher fees. It also provides an indication of the amounts that local authorities may recover from residents (or their estates) who have entered into deferred payment arrangements after the sale of their property.

Standard fees for placements in residential care homes vary from a minimum of £414 to a maximum of £509, with a median value of £470 in 2013/14. As expected, the fees for Very Dependent Elderly and especially Elderly Mentally Infirm are typically higher than the standard charge (although in some local authorities they are set at the same level) and vary between £428 and £543, with a median value of £472 in the case of VDE, while the range for EMI is £463-£587, with a median fee of £506.

Standard fees for placements in care homes registered to provide nursing care (excluding the LHB contribution) are in the range of £427-£629, with a median value of £503, while fees for EMI nursing are typically slightly higher, ranging from a minimum of £487 to a maximum of £683 and with a median value of £530.

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<td>Older People Residential VDE</td>
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<td>Minimum</td>
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<td>Median</td>
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<td>Maximum</td>
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Note: N denotes the total number of local authorities providing information on contributions for each type of residential care service provided. The median identifies the value lying at the midpoint of the frequency distribution of observed values, such that there is an equal number of values above and below it. Local Health Board contribution in 2013/14 was set at £120.56 in most local authorities, but at least two local authorities reported a LHB contribution of £129.59.

VDE Very Dependent Elderly; EMI Elderly Mentally Infirm.
Source: LE Wales based on a survey of Welsh local authorities.
4 Deferred Payment Schemes

One of the key characteristics of the financial assessment undertaken by local authorities on individuals in need of residential care services is that housing wealth is fully taken into account unless it is the home of another person in a qualifying category within the charging regulations. In such circumstances the property is fully disregarded. The existing level of the capital limit in Wales and the upper limits in the rest of the UK (all with thresholds around £24,000) means that individuals owning the property they have been living in are almost certain to fall outside the capital limit and so could need to fund their care through the sale of their property, unless they have other liquid assets or sufficient income they can use to cover the care fees.

Effectively, this means that those not owning their home and not having other assets above the thresholds will only have to contribute to the care fees out of their eligible income. On the other hand individuals having a considerable amount of other assets or income can use these sources to self-fund their care services and do not necessarily need to sell their homes. The third category is formed by individuals who own their home, but do not have enough other assets or income to fund their own residential care. These home owners are requested to transform their housing wealth into liquid assets and therefore to sell their property within 12 weeks of entering residential care.

To avoid requiring individuals to sell their property during their lifetime, local authorities can offer home owners who move into residential accommodation and who do not have sufficient income and other assets apart from their home the option to defer the care charges. Under a deferred payment scheme, the local authority will pay the residential care fees in full and put a legal charge (similar to a mortgage) on the care home resident’s property. Care home residents are still required to pay a contribution to the local authority based on their eligible income (and subject to the personal expenses allowance). The local authority will then recover the money when the property is sold (before or after the death of the resident) or if the resident decides to terminate the agreement.

4.1 Deferred Payments in Welsh local authorities

In Wales, local authorities are required to have a deferred payment scheme in place. However, the characteristics of the deferred payment scheme and whether to enter into specific agreements are left to the discretion of each local authority.

Table 5 summarizes the recurring characteristics of deferred payment. One of the key features of the schemes is the current inability of local authorities to charge any interest during the life of the agreement, meaning that the scheme is run at a loss. This means that local authorities may have limited incentives to promote deferred payment schemes.

As part of the survey of local authorities undertaken we enquired about the number (and type if possible) of individuals entering a formal deferred payment agreement over the last three years and also (when available) the number of individuals declining an offer of a deferred payment. We also asked to confirm whether interest was chargeable after the termination of the agreement (and the level of the interest rate) and to add any relevant detail on the characteristics of the scheme compared to the recurring characteristics outlined in Table 5. In total 19 out of 22 local authorities were able to provide information on deferred payment schemes. Summary information collected from local authorities is presented in Table 6.
### Table 5: Recurring characteristics of deferred payment schemes

<table>
<thead>
<tr>
<th>Eligibility Criteria</th>
<th>Loan Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To join the scheme users must:</strong></td>
<td></td>
</tr>
<tr>
<td>have been assessed by Social Services as needing residential or nursing care</td>
<td>The loan is interest free during the life of the agreement</td>
</tr>
<tr>
<td>be eligible for Council funding (i.e. savings and other assets must be below the £23,750 threshold)</td>
<td>The debt must be repaid when the agreement finishes. This could be either:</td>
</tr>
<tr>
<td></td>
<td>o when the property is sold;</td>
</tr>
<tr>
<td></td>
<td>o when the resident terminates the agreement;</td>
</tr>
<tr>
<td></td>
<td>o within 56 days of the resident’s death;</td>
</tr>
<tr>
<td>have a beneficial interest in a property they have been living in, whose value is enough to pay back the estimated cost of the loan</td>
<td></td>
</tr>
<tr>
<td>pay a one-off administration fee if required by the local authority</td>
<td>Interests may be charged after termination of agreement or from the 57th day after the resident’s death</td>
</tr>
<tr>
<td>pay a weekly contribution based on the financial assessment of their income</td>
<td></td>
</tr>
</tbody>
</table>

Note: Details of single schemes may vary across local authorities

*Source: LE Wales based on information provided on Local Authorities’ websites*

Overall, most responding local authorities reported a very low number (less than 10 per year) of new deferred payment agreements started in each of the last three years\(^{22}\). Only in 4 local authorities was the number of new agreements on average more than ten in the last three years, with two local authorities recording almost 30 new deferred payments in 2013/14 (however one additional LA was unable to provide the number of new agreements in any of the years, but reported a total of 191 existing deferred payments, which suggests that the annual number of new deferred payments is probably in excess of 30).

In total responding local authorities able to provide information on new deferred payments reported 89 new agreements in 2011/12, 84 in 2012/13 and 130 agreements in 2013/14. Some local authorities were also able to report the number of clients declining an offer of a deferred payment.

### Table 6: Deferred Payments in Welsh LAs

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Number of new deferred payments</th>
<th>Number declining a deferred payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011/12</td>
<td>2012/13</td>
</tr>
<tr>
<td>Total agreements</td>
<td>89</td>
<td>84</td>
</tr>
<tr>
<td>Maximum per LA</td>
<td>29</td>
<td>21</td>
</tr>
<tr>
<td>LAs with at least 10 agreements</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>N</td>
<td>15</td>
<td>17</td>
</tr>
</tbody>
</table>

Note: Total number of new agreements refer to the total calculated on responding Local Authorities reporting valid information on the number of new deferred payments; the Maximum per LA identifies the highest number of new agreements recorded in a single LA; LAs with at least 10 agreements identify the number of LAs reporting at least 10 new deferred payment agreements; N identifies the number of local authorities reporting valid information for each question.

*Source: LE Wales based on a survey of Welsh local authorities*

Other information gathered from local authorities covered the interest rate chargeable after the termination of the agreement (ranging from the Bank of England base rate to BOE base rate+8%).

\(^{22}\) A number of local authorities also reported cases where residents are unable or not willing to sell their home within the 12 week disregard period, but do not enter any formal deferred payment agreements. In these cases the local authority places a legal charge on clients’ properties to secure debt incurred from residential or nursing care and recovers the debt when the property is sold.
Local authorities highlighted a series of difficulties in extending the take-up of the scheme further. For example, local authorities mentioned the following cases where a formal deferred payment could not be agreed:

- Mental capacity issues – where a client does not have mental capacity in relation to his/her financial affairs and there is no appointed Attorney/Deputy to act on their behalf;
- Families not wishing to engage with the Local Authority in providing assistance to establish a client’s financial position;
- Where a property is jointly owned and has more than one beneficiary, it is not always possible to register a charge at Land Registry;
- Property issues – e.g. restrictions on title, equity release, other registered charges (e.g. Mortgage) may restrict the registration of a charge by the Local Authority;
- Cases where title to properties at the Land Registry have not been rectified if, for example, the spouse of a resident who was a co-owner has passed away;
- Cases where the agreement triggers first registration of an unregistered property;
- Cases where properties are being held as tenants in common\(^23\) and therefore the Authority has to value the share as nil even if the property is empty\(^24\);

Most of the problems encountered by local authorities are associated with the registration of the property at the Land Registry. They outlined that the process is becoming more labour intensive and costly.

Five local authorities were also able to provide summary information on the characteristics of residents entering a deferred payment agreement. Looking at the summary data aggregated over the three-year period, and based on an overall sample of 188 individuals, the main characteristics of residents entering a deferred payment agreement can be summarised as follows:

- The age range reported is very wide, covering individuals aged between 64 and 104, but the majority of individuals are aged 85 and above, and the average age is around 88. Aggregate figures for Wales show that the group aged 85 and above accounted for 62% of total residential placements in 2012/13\(^25\).
- There is typically a strong female prevalence, with female residents accounting for around 75% of total new deferred payments. This is a slightly higher rate than the gender distribution in the population aged 85 and above: according to the ONS population projections for 2014, around two thirds of Welsh residents aged 85 and over are females;
- Approximately two thirds of new deferred payments in the last three years were agreed by individuals in residential care (and the remaining third by individuals in nursing care). This is remarkably consistent with the most recent Welsh figures on the number of adult placements in care homes for both the group aged 65 and above and the group aged 85 and above (the ratio was 65.5% and 66.5% respectively in 2012/13).

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\(^23\) With joint ownership of a property, both owners own the whole of the property, so when one owner dies, the other automatically becomes the sole owner of the home. With tenants in common, each owner only owns a set share of the property (half or any other share).

\(^24\) Under 7.013 Joint beneficial ownership of property – CRAG Guidance

\(^25\) Individuals in the older age group are also less likely to have the value of the house disregarded because an eligible person (e.g. spouse) continues to live there and thus more likely to be interested in deferring payments.
Clearly, these statistics are based on a sample of only 5 local authorities and on a limited number of observations (less than 190 on aggregate), so the data presented should be treated with caution. However, they do provide some indication on the characteristics of residents entering deferred payments and they are also in line with expectations based on the national statistics.

We also enquired about the number of individuals declining an offer to enter a deferred payment agreement. Some local authorities reported not to record that type of information, while other LAs were not aware of any case of individual declining an offer of a deferred payment agreement. Other local authorities reported the number of cases where it was not possible to start a deferred payment agreement. However, the figures reported are likely to encompass both cases where residents (and their families) decided to decline an offer of a deferred payment agreement and cases where, due to a series of reasons not depending on the resident’s will (as detailed above), it was not possible to put a legal charge on the property.

In the remainder of the section we introduce deferred payment schemes in England, which are part of the proposed reforms contained in the Draft Care and Support Bill.

4.2 Deferred Payments in England

The existing situation in England has been summarized by the Department of Health as follows: “since 2001, local authorities have discretionary powers to defer self-funders’ residential care fees against a charge on property. However, provision of these deferred payments is patchy, as local authorities can set their own eligibility criteria and cannot charge interest, thus making a loss on every deferred payment.”\(^6\) Although guidance from the Department of Health states that local authorities may be acting unlawfully if they offer no deferred payment scheme, no specific characteristics of the scheme are set out and the decision to offer a deferred payment in individual cases are left to the local authority’s discretionary judgement.

The Department of Health\(^7\) estimates that each year approximately 55,000 individuals in England enter residential care as self-funders. Of these, 35,000 have non-housing assets below the national eligibility threshold (£23,250 in 2013/14), but only 4,000 a year actually enter a formal deferred payment agreement with the local authority. The current take-up rate in England can therefore be estimated at 7.2% of total self-funders and 11.4% of self-funders fulfilling the eligibility criteria on non-housing assets.

4.2.1 Survey of English local authorities

A survey of English local authorities by the Department of Health\(^8\) in 2013 enquired about their provision of deferred payment schemes. The survey received a total of 59 responses and showed that a wide variation existed both in the characteristics of the schemes offered and the take-up rate across local authorities. From the survey it emerged that a number of local authorities had restrictive conditions on eligibility, concerning, for example, whether the house was occupied (by a relative or tenant), or strict liquid assets limits. The take-up rate was around 9% in those local authorities having stricter access conditions and 14% in those having no restrictive access.
conditions. Overall, the Department of Health estimated that, of the 152 local authorities, approximately 80 only had a negligible number of deferred payments being taken out each year.

Other aspects of the survey of local authorities included collecting information on the length of deferred payment agreements and the time that it takes for the loan to be repaid after the end of the agreement (due to termination of the agreement by the client or client’s death). Overall, 47% of all deferred payment agreements lasted less than one year, 28% between 1 and 2 years, 14% between 2 and 3 years and 11% more than 3 years. The average length of a deferred payment was estimated in 1.5 years.

Information on late repayments after the end of agreement showed that only 50% of deferred payment loans were repaid within six months (30% within 3 months), a further 40% between 6 months and one year and 10% were repaid after more than one year. As already mentioned, local authorities currently already have the power to charge interests on late repayments.

The survey also enquired about administration costs, but only a small number of the surveyed authorities (20 out of 59) were able to provide estimates, with costs ranging from £170 to over £1000. Based on an in-depth case study, the Department of Health estimated that total administration costs for each deferred payment were around £680, with legal costs accounting for more than half of the total.

4.2.2  UK Government policy proposals for England

Following recommendations by the Dilnot Commission, the UK Government announced the introduction of a universal deferred payments scheme from April 2015 (one year before the other announced reforms will take place). The Draft Care and Support Bill was published in July 2012 alongside a consultation to investigate stakeholders’ views on the proposed reforms. The proposed scheme will be offered by all English local authorities and will cover all people needing residential care, meaning that people will no longer have to sell their home to pay for care home fees during their lifetime.

The proposed policy introduces a series of key changes on deferred payment schemes, providing consistency across local authorities and greater certainty on eligibility criteria. Key changes under the proposed policy can be summarized as follows:

- Local authorities will have the duty to offer a deferred payment scheme to individuals in need of residential care services and with non-housing assets below the capital threshold (currently £23,250);
- LAs will be allowed to charge an interest rate on deferred payment agreements to cover the cost of the loan. To ensure consistency and fairness throughout England, the national maximum chargeable rate will be set by the UK Government.
- The eligibility criteria are intended to be flexible, for example with the possibility for local authorities to offer deferred payments also to people having non-housing assets slightly

29 These estimates are based on the figures provided by the sample of local authorities responding to the questionnaire (59). Estimates at the England level are based on the annual budget survey by ADASS and Department of Health modelling and also cover LAs currently offering a negligible number of deferred payments.

30 “Fairer Care Funding: Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support” Vol II, page 58. July 2011

31 “Caring for our future - Consultation on reforming what and how people pay for their care and support”. Department of Health, 2013
above the capital threshold. However, there have also been calls to extend the scheme to all self-funders entering residential care, irrespective of the level of non-housing assets.

- Local authorities will also be able to charge an administration fee to cover the upfront costs of offering a deferred payment, covering for example the costs associated with placing a charge on a property to secure the debt. Currently local authorities are able to charge an administration fee (typically between £100 and £120), but the UK Government is seeking to make clarity on what costs local authorities can include in the administration fee and the level of the costs.

- Under the proposed policy design, local authorities will have the duty to administer deferred payment schemes, though there have been calls from local authority organisations for the introduction of a national body to oversee and administer the deferred payment scheme.

4.2.3 Policy impacts: take-up

The Department of Health estimated three scenarios for the take-up of revised deferred payment schemes in the 10-year period following the introduction of the proposed scheme. The take-up rate is defined as the number of individuals accessing a deferred payment scheme each year, divided by the total number of new self-funders. Estimates are based on the following assumptions:

- The first scenario assumes that the take-up rate will stay constant at the current rate (7%);
- The second scenario assumes that the take-up rate will evolve in line with current take-up in local authorities with no explicit access restrictions (14%);
- The third and main scenario is based on the current take-up rate in one local authority with a large number of deferred payments, a high level of awareness and a well-developed scheme and is set at 20%. This is defined as the main scenario (clearly subject to uncertainty on future take-up trends) as the universality of the proposed scheme will raise awareness and availability to clients, leading to higher demand. Focusing only on self-funders who are eligible or interested in taking up deferred payments (around two thirds of the total), the take-up ratio is around 30%.

A summary of the estimates published by the Department of Health on the future number of clients taking up deferred payments is available in Table 7 below. The published estimates for the main scenario (Scenario 3) suggest that the proposed policy will lead to an increase in the take-up of deferred payment schemes in excess of 11,000 compared to the scenario using the current take-up rate (as shown in the last column of Table 7, estimates predict that the number of new deferred payments in 2024/25 will be 6,200 using the current take-up rate (7%), but 17,600 with the 20% take-up rate).

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32 Impact Assessment no. 7084. Department of Health, May 2013
Deferred Payment Schemes

Future of Paying for Social Care in Wales

Table 7: Deferred payments take-up in England under the proposed policy, 2015/16 – 2024/25

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>New self-funders</td>
<td>62,000</td>
<td>63,000</td>
<td>65,000</td>
<td>68,000</td>
<td>71,000</td>
<td>74,000</td>
<td>77,000</td>
<td>81,000</td>
<td>85,000</td>
<td>88,000</td>
</tr>
<tr>
<td>Scenario 1 (7%)</td>
<td>4,300</td>
<td>4,400</td>
<td>4,500</td>
<td>4,700</td>
<td>5,200</td>
<td>5,400</td>
<td>5,700</td>
<td>6,000</td>
<td>6,200</td>
<td></td>
</tr>
<tr>
<td>Scenario 2 (14%)</td>
<td>8,600</td>
<td>8,800</td>
<td>9,100</td>
<td>9,500</td>
<td>10,300</td>
<td>10,700</td>
<td>11,400</td>
<td>11,900</td>
<td>12,300</td>
<td></td>
</tr>
<tr>
<td>Scenario 3 (20%)</td>
<td>12,300</td>
<td>12,600</td>
<td>13,000</td>
<td>13,500</td>
<td>14,800</td>
<td>15,300</td>
<td>16,200</td>
<td>17,000</td>
<td>17,600</td>
<td></td>
</tr>
</tbody>
</table>

Note: Figures rounded to the nearest hundred. All figures refer to the annual number of new clients. The number of new self-funders is the base for the calculations of the take-up of new deferred payment agreements and does not vary across the different scenarios. The number of new deferred payments is then computed as [New self-funders x Take-up rate] for each scenario.

Source: Department of Health, 2013

4.2.4 Policy impacts: costs

Information collected from local authorities and other inputs were used to estimate the cost of deferred payment schemes under the proposed policy changes. The estimates also take into account concurrent policy changes in capital thresholds and the care costs cap. The main assumptions behind the estimates were the following:

- an average weekly fee of £610 for self-funders;
- an average income contribution of £220;
- the difference will be deferred (approximately £380 per week and £20,000 per annum);
- the duration of deferred payments will reflect the information collected in the survey of local authorities;
- the interest rate is set at 4%;
- a 2% rise in care costs from 2015/16 onwards;
- no late repayments or default risk.

Deferred payment costs were estimated under Scenario 2 (with a 14% take-up rate) and Scenario 3 (20% take-up rate) described above and then compared with the cost of the baseline scenario (current policy, with a 7% take-up rate). The additional funding needed compared to the baseline scenario is presented in Table 8. The calculations take into account all payments and repayments related to new deferred payment agreements taken out between 2014/15 and 2024/25, including those taken out within the period but repaid after 2024/25. New agreements taken out after 2024/25 are outside of the ten year assessment period and not part of the calculations.

Additional costs compared to the existing situation reflect the additional number of clients entering deferred payment schemes, while additional revenues are driven by the possibility of charging positive interest rates (compared to no interest rate under the current policy). The net effect is estimated to be positive (i.e. reduced overall funding) over the 10-year period considered by the analysis. However, additional funding will be needed in the transitional period, with a reduction in costs only estimated to take place from around 2024/25.

Table 8: Additional funding needed for deferred payments in England, 2015/16 – 2024/25

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario 2 (14%)</td>
<td>£22m</td>
<td>£40m</td>
<td>£35m</td>
<td>£24m</td>
<td>£13m</td>
<td>£9m</td>
<td>£4m</td>
<td>£3m</td>
<td>£1m</td>
<td>£225m</td>
<td>£-73m</td>
<td></td>
</tr>
<tr>
<td>Scenario 3 (20%)</td>
<td>£41m</td>
<td>£74m</td>
<td>£66m</td>
<td>£47m</td>
<td>£28m</td>
<td>£20m</td>
<td>£13m</td>
<td>£12m</td>
<td>£10m</td>
<td>£407m</td>
<td>£-92m</td>
<td></td>
</tr>
</tbody>
</table>

Note: Additional funding needed compared to Scenario 1 (7% take-up rate). All figures in 2010/11 prices, rounded to the nearest £m.

Source: Department of Health, 2013
5 Care-related financial products

The only significant insurance product available specifically for care costs in the UK is an immediate-needs annuity. The equity release market also offers individuals the ability to unlock wealth held in residential property for purchasing social care directly (or indeed, through an immediate-needs annuity). However, equity release cannot usually be used for residential care and can conflict with eligibility for receipt of some benefits.

There is no public information about the level of take up of care-related financial products in Wales. Our stakeholder consultation suggests that take up of immediate needs annuities may be relatively low in Wales. For one immediate-needs annuity provider serving the UK, only 2% of policyholders are based in Wales (one would expect this figure to be approximately 5% if the number of policyholders were proportional to the population). The extent to which equity release is used for paying for care as opposed to other purposes is also unclear.

Looking to the future, there are a number of potential financial products, new as well as revised/adjusted existing products, specifically aimed at social care that could be introduced or reintroduced into the marketplace.

Yet, before introducing new products, and in light of the possibility that take up is presently low, public awareness of social care costs and the potential need for individuals to contribute towards them may well need to be improved. Suggestions of how this could be done are considered in this chapter and include incorporating social care considerations into later-life planning in general and having local authorities identifying independent financial advisers for potential consumers of care-related financial products.

5.1 Financial products currently available

The majority of financial products for social care is aimed at older people, since older people as a group, are more likely to need care. General retirement income products and investment bonds can be used to pay for care; however, they are not designed specifically to address later life care and may not provide sufficient capital. More specifically, general retirement products and investment bonds do not help individuals to insure against uncertainty regarding the duration of care needs. For these reasons, some individuals take up annuities to pay for care.

5.1.1 Annuities

Description of available products

An annuity is a financial product that involves the transfer of a lump sum of capital from the individual to the annuity provider in return for a regular stream of income upon annuitisation (commencement of payments in pre-agreed intervals after a certain period of time).\(^\text{33}\)

There is an established market for point-of-need financial products for people entering care, where the only significant tailored product is an immediate-needs annuity, also known as an

\(^{33}\) Annuities are most commonly purchased through pension scheme lump sums on retirement.
immediate care plan or a care fees annuity. Other products that may be used to contribute to the cost of care are deferred care plans and enhanced annuities.

An immediate-needs annuity is taken when a person is moving into residential or nursing home, but it can also be used for home care. A person taking out this type of annuity pays a lump sum to the provider, who is then responsible for paying the care costs for the whole duration of the annuity holder’s life. The lump sum is usually calculated based on the income the person requires, their age and health at the time of the application (that is, they are medically underwritten). Disbursements can either be in regular equal payments, or index linked to rise over time. The policyholder can choose whether to receive the payments himself/herself (in which case they will be taxed) or whether they should be directly paid to a carer or care home (free of tax if the provider is registered with the Care Quality Commission). The average monthly benefit of an immediate needs annuity in England recently was £1,600 and the mean purchase price was £80,000.\textsuperscript{34} One financial services provider consulted as part of the research observed that its typical policyholder would derive income from the annuity for four years (however, their typical policyholder purchase price and monthly benefit differed from the averages for England).

A deferred care plan, or a deferred care annuity, for long-term care, defers the stream of income by a few months or years and allows policyholders to agree on a fixed period of time for their care. Similar to an immediate-needs annuity, a lump sum is used to purchase a deferred care annuity. A deferred care plan may be cheaper than an immediate care annuity. This is because the payments do not proceed straight after the start of the plan, but after a specified amount of time – the longer the deferment period, the lower the cost to the individual for a given monthly benefit will be; in addition, the duration over which payments are made is fixed. During the deferment period (before the stream of payments commences), the policyholder is responsible for meeting the costs of their care.

An enhanced annuity, also known as an impaired life annuity, can be purchased when a person has a health problem, a long-term illness, is overweight or smokes. Enhanced annuities offer higher payments over the course of the policyholder’s lifetime than standard annuities (since the life expectancy of an enhanced annuity-holder is deemed lower), but are not specifically aimed at long-term care. Full medical underwriting is used by the annuity provider when estimating individual prices and disbursements.

**Take up of products**

Information on take up rates of long-term care annuities is scarce; however selected estimates have been made available through existing survey work and a stakeholder consultation carried out with financial services providers\textsuperscript{35} as part of this research.

According to the 2011 Laing & Buisson UK Market Survey of care for the elderly, around 1,000 immediate-needs annuity policies were taken out each year in England alone.\textsuperscript{36}

\textsuperscript{34} Commission on Funding of Care and Support (2011), ‘Fairer Care Funding: Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support’, p. 164

\textsuperscript{35} Including insurance providers, brokers and associations representing these organisations.

One immediate-needs annuities provider observed that 2% of immediate needs policyholders are based in Wales.

The above provider also noted that immediate-needs annuity policyholders are mainly based in urban areas, namely Cardiff, Newport and Swansea, and also speculated that this could in part be due to more affluent individuals being based in cities (and more affluent individuals being more likely to take out immediate-needs annuities) and that financial services providers are more easily able to distribute policies in cities.

5.1.2 Equity release

Equity release is not related to paying for care per se – housing equity can be monetised for any purpose. However equity release is briefly considered in this chapter because it may be used to unlock wealth held in residential property to pay for care or to purchase a care-related annuity.

There is a widespread equity release market, which enables people to purchase care annuities without having to sell their home. The amount of equity that can be released from a person’s property usually depends on the value of the property and the policyholder’s age at the time of application.

However, equity release reduces the value of the property and may also affect the policyholder’s entitlement to state benefits (for example, deferred payment for care) as a result of change in his/her wealth.

In addition, it is possible for equity release to be used for domiciliary care, but not for residential care. Equity release products require the property to be sold when the policyholder goes into residential care and are therefore unsuitable to finance this type of long-term care.

Finally, if equity release is used for social care but not structured carefully (e.g., to fund the purchase of an immediate-needs annuity) the tax burden could be higher than it need be.

5.2 Anticipated future developments and suggestions

The UK Department of Health conducted an industry consultation, with the Association of British Insurers among others, and presents an outline of suggestions for future development of financial products aimed at social care. The work was conducted in response to paying for care reforms in England, but is likely to be relevant to consumers in Wales as well.

The recommendations of the industry consultation organised by the Department of Health include that further flexibility should be added to existing products. There is a role for flexible protection products, for instance a life insurance policy being used to pay off the loan from a deferred payment arrangement. Such products would benefit from easier distribution channels, since they

37 Note that this judgement was based on postcodes for these cities, which may cover a much broader area than would normally be considered as being a part of those cities.

38 Though the extent to which this is happening is not known.

39 Exceptionally, equity release may be used for domiciliary care, for instance if a couple wished to release equity to fund care in the home, as suggested by a financial services provider consulted as part of this research.

build on existing products that people purchase during their working life and are thus already familiar with.

There is also the possibility of bringing back previously offered products, such as disability-linked annuities, hybrid products and conversion products.

- **Disability-linked annuities** reduce the income from a flat annuity but then increase it when a triggering care need arises assessed by failing Activities of Daily Living. Disability-linked annuities were launched in the early 1990s for a brief period of time but this product was withdrawn from the market following an objection from HM Revenue & Customs that such a product could not be treated as a pension and receive the accompanying tax concessions. HM Revenue & Customs argued that the reason for an increase in the annuity was a change in health status (the individual becoming disabled) and therefore it could not be considered pension.  

- **Hybrid products** cover care risks as well as other risks. For example, care insurance could be an added option on a standard protection policy or on a pension plan. Hybrid life insurance policies allow individuals to purchase a cash-value life insurance policy and use a portion of it for long-term care benefits, if a care need arises. The rest can be kept as a death benefit that will be paid to the purchaser’s beneficiary. If long-term care benefits are used, the death benefit may be reduced.

- **Conversion products** transform from protection of traditional risks to protection of care risks, when a care need arises. For example, an income protection policy that switches to care insurance at retirement.

The industry, represented by the Association of British Insurers, expects there to be a range of products that can be combined or used individually, rather than a single, comprehensive product.

### 5.3 Raising awareness

The Commission on Funding of Care and Support (in England) suggested that there was a lack of awareness of how the current system of paying for care works, saying:

> "Currently, many people are unaware of how the system operates. Many believe they will receive free care in later life and are often shocked when they discover the scale of their financial liabilities at the point that they, or a family member, need care."  

This view was supported in our consultation with stakeholders in the financial services industry. It suggests that activities to raise awareness of the potential need to pay for social care and the available financial solutions are required.

On this point, the Commission suggested that social care should be re-framed in the wider context of later-life planning, especially with pensions, since care needs usually arise later on in a person’s life. People might be reluctant to think about social care alone, but by linking it to pensions and

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later-life they can consider it in a broader scheme when planning their retirement. They also suggested that people already with care needs should be presented with an outline of the care-funding options available to them, in order to increase their understanding of the various financial products.\textsuperscript{43}

Stakeholders consulted as part of our research emphasised the importance of local authorities playing a role in bringing together potential consumers of financial products for social care and regulated independent financial advisers. It was noted that while local authorities may be able to signpost financial options that people in need may wish to consider, they were not qualified to give detailed information and advice on financial products, which is the role of appropriate regulated persons.

One stakeholder also highlighted that many market-enabling factors were required to develop the market for social care-related financial products. In particular, it was stated that to make the insurability of social care feasible, and therefore allow for growth in social care-related financial products, sufficient demand needed to be established through investment in awareness-raising, which is not close to being established at the present time.

Given the context of having insufficient demand for the development of social care-related financial products, it was suggested that equity release products were a key near-term solution for individuals to use for their contributions to the cost of social care. It was claimed there is £800bn of unmortgaged equity in the UK among those aged 65-80 and measures should be taken to encourage access to wealth stored in property – at a much earlier age than at the point of need.

\textsuperscript{43} Commission on Funding of Care and Support (2011): ‘Fairer Care Funding: Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support.’
6 Paying for care: alternative models

6.1 Introduction

Most people who need social care services are elderly. Before reaching this stage in their lives, people cannot usually anticipate with any uncertainty whether or not they will ever need social care services and, if they were to need them, when that would be and what type and volume of services they would need, as well as how much those services might cost.

Even for those with sufficient income to save towards, and pay for, potential future care costs, these uncertainties make planning ahead for care very difficult. The costs of care services can be high and many on low incomes would not be able to pay for suitable care services themselves.

In this Chapter, we first briefly discuss, at the level of principle, some high level models for paying for care and then we provide an overview of some of the relevant characteristics of the types of paying for care model that are used in practice. Finally, we provide summaries of the paying for care models used in each of eight countries:

- France
- Germany
- Sweden
- Japan
- Australia
- England
- Scotland
- Northern Ireland.

6.2 Paying for care models in principle

6.2.1 Private payments

One potential model is for Governments not to play any role in paying for social care services and to leave it to individuals, together with their families, to plan and pay for their own care. This would put many people in a difficult position financially, though some undoubtedly can and do look after themselves in this way.

Financial products can help people to manage their own funds for these purposes, ranging from standard savings and investment products that enable a ‘lump sum’ to be accumulated over time to insurance products aimed specifically at meeting social care costs. The current limited availability of suitable financial products in Wales and elsewhere in the UK is discussed in the previous Chapter.

None of the paying for care systems that we have reviewed as a part of this research takes this approach. They all involve some Government role in paying for care.

6.2.2 Public payments

At the other end of the spectrum, an alternative model is that Government pays for all care costs for all citizens.
Ultimately the Government derives most of its revenue through the tax system, which most citizens contribute towards, and this model could be viewed as a type of risk pooling or insurance mechanism that spreads the risks of needing to pay for care across the population. In a system based on general taxation there would not be any direct link between payments of tax by citizens and expenditure on care services.

A slightly different alternative would be to have a specific national fund which citizens pay into and which then makes payments for the care services required by citizens. In this system there would be a link between the total amount that citizens pay into the fund and the total expenditure on care services, though there would not necessarily be a link between the amounts that individuals pay and the value of care services that they receive. This would be similar to the way in which the National Insurance Fund in the UK works. Employees and employers pay National Insurance Contributions (NICs) and about 80% of revenues from NICs are paid into the National Insurance Fund. The Fund is used exclusively for paying contributory benefits, such as elements of Jobseekers Allowance, Incapacity Benefit and the state pension.

None of the paying for care systems that we have reviewed as a part of this research takes the approach that all care services for all citizens are paid for by the Government. They all involve some role for individual services users in paying for their care.

6.2.3 Mixed public-private models

The reality in most countries is that care costs are funded through mixed public-private models involving various combinations of private and public payments, with the management of private funds over time often assisted by bespoke financial products. The latter are sometimes obligatory and sometimes optional.

6.3 Paying for care models in practice

As indicated above, paying for care models in practice include a mix of payments for care by users and State funding. In the remaining sections of this Chapter we provide a summary of the paying for care model in each of eight countries (including the other parts of the UK).

Table 1 below provides a summary of some of the relevant characteristics of the paying for care models operated by these eight countries, covering:

- the proportion of the elderly population that use care services;
- any specific constraints on the payments by service users for their care services;
- a comment on care related financial products; and
- an indication of the proportion of total care costs contributed by users.

The information in the table should be treated with caution. It is derived from many different sources and covers information for different years. The services provided in different countries are also different and so many items in the table are not necessarily directly comparable. They do, however, serve to give a broad indication of the differences across these countries.

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44 The remaining 20% of NICs revenue is paid to the National Health Service, though this accounts for a relatively small part of NHS spend (18% in 2006-07).

45 In some years the National Insurance Fund is insufficient to pay all contributory benefits and in these years additional funds are provided from general taxation.
Table 9: Some characteristics of alternative paying for care models

<table>
<thead>
<tr>
<th>Country</th>
<th>Proportion of elderly who use care services</th>
<th>Specific constraints on service user payments</th>
<th>Care related financial products</th>
<th>Proportion of care costs contributed by users</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wales</td>
<td>14% of over 65s use LA care services (2012/13): 11% - non-residential care; 3% - residential care</td>
<td>Means tests and £55/week cap for non-residential care (from April 2014)</td>
<td>Some voluntary care related annuities</td>
<td>20% of LA care service costs covered by charges: 10% for non-residential; 30% for residential users</td>
</tr>
<tr>
<td>England</td>
<td>9% of the over 65s use LA care services (2010): 7% - non-residential care; 2% - residential care</td>
<td>Means tests and a lifetime cap of £72,000 (from April 2016)</td>
<td>Some voluntary care related annuities</td>
<td>13% of LA arranged service costs paid by users (£2.5bn in 2012/13). Estimate of a further £10bn paid for self-funded care (2010/11)</td>
</tr>
<tr>
<td>Scotland</td>
<td>9% of the over 65s use LA care services (2010/11): 6% - non-residential care; 4% - residential care</td>
<td>Free personal care for the 65+ and means test for accommodation costs</td>
<td>Some voluntary care related annuities</td>
<td>Contribute to accommodation costs only</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>7% (19,800) of the over 65s were non-residential care users (2012)</td>
<td>Most services in the home are free. Means test for residential care.</td>
<td>Some voluntary care related annuities</td>
<td>-</td>
</tr>
<tr>
<td>France</td>
<td>11% of over 65s received social care services (2007): 7% non-residential care; 4% residential care.</td>
<td>Means tests</td>
<td>Voluntary private long-term care insurance – fixed cash benefit</td>
<td>Non-residential: av. co-payment 17% Residential: av. co-payment 39% (APA scheme in 2007)</td>
</tr>
<tr>
<td>Germany</td>
<td>11% of the over 65s (2009): 8% residential care; 4% - non-residential care</td>
<td>Fixed contribution rates to (public) insurance schemes for employees</td>
<td>Compulsory (public or private) long term care insurance – both employers and employees contribute at fixed rates</td>
<td>Substantial co-payments (variable) – cash and in-kind benefits not designed to cover full need. Employees pay 53% of contributions to the care insurance scheme, with employers paying the remaining 43%.</td>
</tr>
<tr>
<td>Sweden</td>
<td>17-18% of over 65s use some care services (all publicly provided)</td>
<td>A cap of £119(^{46}) per month (2007), which is means-tested and reduced for low-income users</td>
<td>Universal insurance through general taxation</td>
<td>Less than 5% (2010)</td>
</tr>
<tr>
<td>Japan</td>
<td>14% of the over 65s (2010). 11% non-residential care, 3% residential care.</td>
<td>Means tests</td>
<td>Compulsory long term care insurance for those aged over 40</td>
<td>Insurance claimants cover 10%, or less, of their care service cost. Half of care costs funded through the insurance scheme, the remainder - from general taxation.</td>
</tr>
<tr>
<td>Australia</td>
<td>29% of the over 65s (2010): 23% in non-residential care; 6% in residential care</td>
<td>Means tests</td>
<td>Some voluntary flexible annuities</td>
<td>5% of non-residential care costs and 32% of residential care costs are paid by users</td>
</tr>
</tbody>
</table>

Note: Further details for each country are provided later in this chapter (except for Wales – see Chapter 2). Rounding errors may mean that some of the disaggregated figures in the table do not sum to the totals.

Source: Various

\(^{46}\) A GBP equivalent was calculated based on an average 2007 exchange rate of SEK/GBP at 0.074.
6.4 France

Long-term care benefits in France are covered by several different pieces of legislation. Eligibility to benefits under the different pieces of legislation is assessed by different examiners. Additionally, there are specially designated funds for the separate types of benefits and allowances covered by the different legislations (European Commission, 2013).

The issue of policy on care of the elderly has been on the political agenda since the mid 1980s, however the first policy did not shape until the mid 1990s. Until then, the responsibility for long-term care in France fell largely onto the family. The main social care policy for the elderly in need of care was the one which applied to the disabled: the Supplement for assistance of a third party.

Since the mid-90s, there have been a number of reforms of the long-term social care system in France, which mirrored the view that the risk of need for care is a social risk. In 2002, the Allowance for loss of autonomy (APA) was created, based on the principle of universal social insurance and with limited provision for recovery from inheritance. The aim of the APA was to address the criticism towards the preceding scheme, from which only 15% of the old and frail benefitted (Da Roit et al., 2007).

The goal of the APA system has been to promote the dependent elderly’s choice of who to receive care from, at the same time creating low-skilled, low-paid jobs in the care sector with the dependents acting as private employers (Morel, 2007).

6.4.1 Coverage

Benefits in-kind

The APA can be used to cover the costs of home care and semi-residential and residential care. It is a controlled needs-based allowance, which is granted on the basis of a single-assessment grid which distinguishes between 6 levels of need. The APA covers the first 4 levels, extending the dependency criteria to increase the number of people eligible compared to the previous system (Morel, 2007). Each level of benefit funds a specific care package, identified as a result of the professionally conducted assessment and according to the level of dependency. Only services deemed necessary by the professionals can be covered by the allowance (Da Roit et al, 2007).

In the case of non-residential care, the assistance required for staying at home is assessed. The amount of the benefit depends on the assistance plan used, taking into account the level of participation of the beneficiary, and calculated according to his/her means.

For semi-residential care, it is possible to receive day care in a specialised centre. The number of hours granted depends on an evaluation of the need of assistance.

With respect to residential care, which includes accommodation in a social or medical-social institution, hospitalisation in a health institution or in an institution for accommodating elderly dependent persons, the amount of the benefit equals the cost corresponding to the degree of loss of autonomy according to the institution’s tariffs, minus the amount covered by the beneficiary themselves (European Commission, 2013).
Cash benefits

The supplement for assistance of a third party is equal to a 40%-increase of the pension, which cannot be lower than a minimum amount fixed by a decree. The amount of supplementary benefit for recourse to a third party depends on the number of activities of daily living which the person concerned is able to perform independently.

The special education supplement for disabled children comprises six categories. There is a specific increase for dependent children of a single parent who is benefiting from the allowance and from a supplement for a disabled child of at least the second category (European Commission, 2013).

There are no cash benefits under the APA allowance.

6.4.2 Funding structure

After the implementation of the APA allowance in 2002, a new reform was implemented in 2004 and the “Plan for frail elderly people” emerged (Da Roit et al., 2007). This plan resulted in the creation of a fund for the frail elderly, which was financed by general taxation as following:

- employers’ contributions of 0.3% of total wages, which was compensated by abolishing 1 day of public holidays;
- 0.1% of income tax designated to financing social security; and
- the transfer of credits for frail elderly and disabled people from the social security fund.

Similarly to the German system, the APA is only meant to complement, rather than substitute, the cost of care covered by the individual and their family (Forder and Fernandez, 2011).

The level of support received by an individual aged 60+ is determined by:

- A need assessment, which determines the level of maximum support that the individual could receive.
- An income assessment, which determines the proportion of the maximum benefit to be met by the insurance fund.

A monthly income threshold of €670 applies: if the recipient’s income is below the threshold, they don’t contribute anything to their care package; if their income is above the threshold, there is a co-payment calculated on a sliding scale, depending on the level of income. Additionally, the APA limits the extent to which the state can use the recipient’s inheritance to recoup care costs. (Morel, 2007) The value of the family home is not included in the income assessment, if it is occupied by an immediate relative. Additionally, each dependent is entitled to a level of personal allowance which amounts to €76 a month, regardless of their income.

There are some slight differences in the funding rules between residential and non-residential care.

Non-residential care: once the level of need is determined, it is used to define the maximum value of the care package. Then the income test is used to determine the level of co-payment by the individual, which can be anything between 0% and 90%. The means-test takes into account the declared income in the individual’s last income tax return, as well as some assets. The value of the
home is disregarded if the individual or their dependent still occupies it (Forder and Fernandez, 2011).

Residential care consists of three components:

- accommodation costs, paid for either by the individual or by means-tested social assistance, depending on the individual’s income;
- nursing care, which is covered by the national health insurance; and
- dependency care, paid for by the user through any APA benefit they receive. A minimum charge for dependency care applies, which is equal to the tariff for lowest-need levels. APA funds are provided to cover charges above the minimum rate, on a sliding scale. The co-payment for personal care can be up to 80%, as opposed to 90% in the case of non-residential care (Forder and Fernandez, 2011).

6.4.3 Uptake

The implementation of the APA in 2002 lead to a very high initial uptake and a rapid increase in the number of recipients compared to the preceding scheme, to 6.5 million recipients by March 2003, which resulted in higher-than-expected costs. To address this issue and lower the costs of the system, the monthly income threshold was reduced from €949 to €670 in 2003 (Morel, 2007).

After the initial burst of users immediately following the implementation of the APA, the absolute growth in beneficiary numbers has been fairly stable, at the rate of around 100,000 additional recipients per year. Most of the growth is attributed to non-residential care users (Forder and Fernandez, 2011).

Out of all applicants, 75% of those for first-time home care and 90% for residential care were approved. As of 31 Dec 2007, the number of APA recipients amounted to 1,078,000, or 11% of France’s population over 65 (Population Reference Bureau and World Bank data), which represents a 5.1% year-on-year increase. 61% of these were non-residential care users, and 39% residential care users (DREES 2008).

In 2007, 44% of all APA recipients were at the lowest level of need (GIR4). 25% of those in residential care are assessed with low level of needs, which implies that further helping people remain in their homes is necessary (Da Roit et.al, 2007). Some of the people with lower level of need not entitled to the APA might still be covered by the home help allowance provided by the pension system. In 2007, the beneficiaries of this allowance were around 230,000.

6.4.4 Cost

Depending on the determined level of need, the maximum APA benefit payable varies between around €520 and €1,210 per month (as of 2008) (Forder and Fernandez, 2011). The average 2007 monthly benefit per recipient of non-residential care is €493. On average, the state contributed €411 per beneficiary, and the average co-payment is €82. The proportion of recipients who made a co-payment in 2007 is 74%. The total annual cost of the APA benefit for non-residential care in 2007 was €3.89 billion, €3.24 billion of which were paid by the state.

The average monthly APA benefit value per recipient of residential care for the corresponding year is €429, with the state contribution being €288 and the average co-payment - €141. The total annual cost of the APA allowance for residential care in 2007 was €2.16 billion, €1.45 billion of which were paid by the state (Forder and Fernandez, 2011).
In total, the APA allowance cost €4.69 billion to the public budget in 2007, which represented 0.3% of France’s GDP (OECD data). The total cost of long-term care in France is projected to increase from 1.4% of France’s GDP in 2007 to between 1.9% and 2.6% of the GDP by 2050 (OECD, 2012).

6.4.5 Advantages

The fixed care packages system enforces tight regulation on the cash-for-care benefit, aiming to boost employment in the care service sector and to prevent the development of a grey market. It is still the recipient’s choice who to employ, and they can choose to employ an unemployed relative other than the spouse as the carer (Da Roit et al., 2007).

The system further incentivises family members to be employed as carers for the dependent by providing a significant tax relief: 50% of the cost of employing a family member is deductible from the family’s income tax. This policy has been particularly successful amongst high- and middle-income families who have a substantial level of co-payment for care. The tax relief policy covers child care and domestic assistance, as well as personal assistance for dependent elderly people (Da Roit et al., 2007).

6.5 Germany

The universal long-term care insurance (LTCI) system is the fifth branch of the German social insurance system, and substituted the previous German means-tested system in 1995. The idea behind the compulsory pay-as-you-go system is that care is a risk that should be borne by society as a whole. The scheme is designed so as to alleviate the individual and family burden of the need for care, rather than to fully overtake their responsibility of care. People can choose between participation in public or private long-term care insurance scheme (Reddemann et al., 2010).

The LTCI covers around 90% of the population in Germany. Need for long-term care, according to the definition employed in Germany, arises when an individual is expected to require regular assistance with daily activities for at least six months as a result of a physical, mental or emotional impairment. Such daily activities include personal hygiene, eating, mobility and general domestic tasks (European Commission, 2013). In Germany, eligibility for long-term care benefits is dependent on the level of need and not on income. For individuals whose cost of necessary care services exceeds the value of long-term care benefits, there are other, means-tested social assistance benefits available (Forder and Fernandez, 2011).

6.5.1 Coverage

In the case of long-term care need, benefits are provided upon request to the statutory long-term care scheme. Beneficiaries are offered a menu of services from which they can choose, capped by their level of assessed need (Campbell, 2010). Levels of support range between approx. €450 and €1,918 per month for in-kind community services and between €1,023 and €1,918 per month for residential care as of 2012, fixed depending on the level of need and without a cap on duration. Benefits in kind include primarily provision of home care and domestic help by carers or outpatient centres, and a lump-sum instalment towards the cost of residential care. Long-term care insurance benefits in Germany do not cover accommodation costs in residential care (Forder and Fernandez, 2011).

Additionally, there are other types of benefits such as short-term care and night care. The long-term care insurance also covers pension insurance contributions and other required insurance instalments for caring family members (European Commission, 2013). In-cash benefits, for those
who wish to provide care themselves, are about 50% of the value of in-kind services (between €225 and €700), and the care user can choose care provision by a family member or by an employed helper. Cash and in-kind benefits can be claimed simultaneously in the relevant proportion chosen by the beneficiary.

The degree of need which determines the amount of benefits received is assessed by the medical service of the sickness insurance. The assessment considers four factors:

- personal hygiene
- mobility
- food; and
- housekeeping

6.5.2 Funding structure

According to German law it is the employer’s responsibility to insure and pay instalments for each employee into a sickness insurance fund of the employee’s choice. Each sickness insurance fund has an affiliated but separate long-term care fund, to which long-term care instalments are automatically forwarded from the sickness insurer chosen by the employee. The long-term care insurance body is independently responsible for granting benefits to beneficiaries.

Employees are obliged to pay 53% of contributions to their long-term care insurance and employers cover the remaining 47%. As of 2013, the total current contribution rate for long-term care insurance is fixed at 2.03% of the salary. Those above the age of 23 and without children pay an additional 0.25%, which reflects the idea that responsibility for care should be shared by society and the family. Currently, the maximum annual earnings used to calculate compulsory statutory sickness and long-term care payments together are 52,200 EUR (European Commission, 2013).

6.5.3 Uptake

The introduction of a national insurance system in 1995 resulted in an increase in beneficiaries. Other forms of means-tested social benefits have become less appealing, falling by two-thirds since 1995.

The total number of non-residential care beneficiaries in December 2009 was around 1,541,100, compared to 702,170 residential-care users, accounting for a total of 2.24 million publicly-provided social care users, or 2.5% of Germany’s socially-insured population (Population Reference Bureau, 2009). Although home care is the more encouraged option, more than 40% of residential care users are assessed to have a low level of need (Bundesministerium für Gesundheit, 2010).

The supply side of the market has expanded and significantly diversified the range of services on offer. Yet, care services in Germany are overall more focused on the medical aspect of care than the services provided in the UK (Forder and Fernandez, 2011).

6.5.4 Cost

Immediately following the reform, there was a steep growth in expenditure of over 100% from 1995 to 1996 and 40% from 1996 to 1997, which exceeded the forecasts (Bundesministerium für Gesundheit, 2010). Since 1997, the average year-on-year expenditure growth rate has been at a stable 3% level, and institutional care expenditure has been growing at a faster rate than home
Paying for care: alternative models

care expenditure. However, the income of the Social long-Term Insurance fund has been growing at a slightly slower rate of 2.5%, which still raises causes for concern to the system’s sustainability. The LTCI scheme expenditure in 2009 was €20.33 billion, or 0.8% of Germany’s GDP in 2009 (OECD Stat Extracts, 2014), with a surplus of liquid funds of €4.8 billion.

Social assistance expenditure has declined significantly since 1995 and amounted to €3.33 billion in 2009 (Bundesministerium für Gesundheit, 2010).

6.5.5 Advantages

In the German system for long-term care, the government regulates the provision of services by issuing licenses and setting service prices, which are constant across regions. Thus, the system is comprehensive and unified, meaning that the government has substantial control of nearly all aspects of the system’s operations, including spending. Additionally, the majority of care service providers in Germany are private and recipients can switch providers. As a result, there is a substantial level of competition on perceived quality of service in the market (Campbell, 2010).

Another advantage of the German system for long-term social care is that it induces provision for care from family and relatives. Although beneficiaries can choose between in-kind and cash benefits, and the cash benefits are around half the value of the home or community service for any level of need, over 70% of beneficiaries choose the cash option, and an additional 15% choose a mix of cash and in-kind (Campbell, 2010). Furthermore, the long-term care insurance is designed to cover the carer’s social security premium and respite care, if the carer is a family member who provides over 14 hours of care a week. This reflects the German system’s aim to make the role of a primary caregiver more attractive than regular employment for family members.

6.6 Sweden

The population over 65-years-old represented 17% of Sweden’s population in 2006 (The World Bank, 2014). This population segment is projected to increase to 25% by 2030 (Edebalk, 2010).

Since the 1950s, responsibility for care for the elderly in Sweden has been, by law, shifted from the individual and their family to society, and this view has been an integral part of people’s welfare culture in Sweden. The idea behind the long-term social care system for the elderly is to empower older people to live a ‘high-quality, independent life for as long as possible’ (Edebalk, 2010).

There are three levels of authority responsible for the regulation and implementation of social care in Sweden – the central government, the county councils and the local authorities. Each of them has the power to raise taxes to finance their care activities. The central government regulates the system, for instance through determining a maximum monthly fee level to guarantee that all the elderly in Sweden who need care are able to receive it. Local authorities are the ones responsible for everything related to the implementation of the care system, so long as there is no healthcare component involved (Fukushima et al, 2010).

Up until the 1990s, home care had not been a big part of the long-term care debate. Residential care was considered as more cost-effective and as being better capable to assist people in need, due to technological progress (Fukushima et al, 2010). However, its focus was on providing costly services for people with high levels of need. Home care has been gaining popularity since the mid-1990s and it has been successful at enabling recipients to lead an independent life for longer. Different stakeholder groups have expressed doubts about whether home care can be an alternative to residential care services, hence the decrease in residential care uptake has come to
a stop (Edebalk, 2010). A rapidly ageing population has also brought more attention to informal care as a potential substitute.

6.6.1 Coverage

All the elderly in Sweden are eligible for long-term social care, subject to a needs assessment. When an assessment is requested, it is the local authority’s responsibility to assign an evaluator, who interviews the person in need and, potentially, their family members. There is no unified assessment procedure or guideline in Sweden. Instead, it is under the evaluator’s discretion to deem a person in need of long-term care. Since 2010, local authorities have also been responsible for implementing a personal care plan for each recipient, so that it is clear who is accountable for care provision and decision-making for each user.

The care services available in the Swedish care system are categorised as:

- home care services;
- residential care services;
- nursing care services; and
- additional services (also provided by the local authorities and also regulated), including:
  - day activities;
  - meals preparation services;
  - home adaptations; and
  - transportation.

Nursing care services can be provided both in a non-residential and residential setting, and in fact, since the late 1990s, they have more and more often been provided at home, since frequent 24-hour home care visits are available for those in need. Institutional care is considered a last resort, mostly in cases where the building is not appropriate for the recipient to remain (Fukushima et al).

6.6.2 Uptake

In 2006, around 1,547,000 people - 17% of Sweden’s population - were of age 65 or older (The World Bank, 2014 and Population Reference Bureau, 2006). A total of almost 18% of this population segment was in receipt of formal long-term care services in the same year. Out of all older long-term care users, around 64% (or 11.5% of all people over 65) were receiving care services in their home, and 36% (6.4% of all people over 65) were receiving services in a residential care institution (Fukushima et al, 2010 and LE analysis).

6.6.3 Funding structure

The long-term care system in Sweden is primarily publicly financed, through general taxation. In 2010, 85% of the long-term care funding came from municipal taxes, 11% - from national grants, and the remaining 4% - from private contributions (Ministry of Health and Social Affairs, 2007; OECD, 2011).

The level of co-payment which the user faces varies according to the means test of the user. Additionally, there is a nationally-regulated ceiling on the monthly fees a provider may charge an individual, which amounted at SEK 1,612 per month in 2007. The ceiling might be further reduced for users with income below the national minimum cost of living (in 2007, the minimum cost of living was around SEK 4,300). In 2009, 19% of home care users where completely exempted from charges (Fukushima et al, 2010).
Informal care providers can also receive support, through a variety of state benefits, support programmes and mechanisms.

6.6.4 Cost

The total expenditure on formal social care for people over 65 represented 3.6% of Sweden’s GDP in 2008 (Fukushima et al, 2010 and OECD, 2011). This level of long-term care expenditure in Sweden is the highest in Europe and amongst all OECD countries (alongside with the Netherlands and other Nordic countries) (OECD, 2011). Less than 5% of social care for expenditure on the elderly was born by the users themselves (Fukushima et al, 2010).

The cost of non-residential care services in 2007 was around €1,900 per capita of population 65+ (Fukushima et al, 2010) (or €22,000 per home care services recipient; or €218 per capita). Residential care costs amount to around €3,000 per capita of population 65+ (Fukushima et al, 2010) (or €51,300 per residential services recipient; or €192 per capita).

In the 2010 budget, SEK 2 billion (approx. €225.8 million) were allocated to financing elderly care (Fukushima et al, 2010).

6.7 Japan

Japan is the country with the second-highest proportion of elderly people in the world, with 23% of the total population people being over 65-years-old (CIA World Factbooks, 2011).

Long-term care for the elderly has been a priority in Japan for the past twenty years (Muramatsu and Akiyama, 2011). The proportion of the pop¬ulation over 65 living alone or living with a spouse only increased dramatically between 1960 and 2006, leaping from 4% to 16% in the group of people aged between 65 and 75 and from 7% to 37% in the population over 75. In contrast, the proportion of those living with a child or other relatives decreased from 87% to 48% in the same period (National Institute of Population and Social Security Research, 2010). The rules regulating social care provision in Japan have been rapidly changing to keep abreast of population dynamics. Anticipating rising long-term care needs, the Japanese government developed a vision in 1989 (Tsutsui and Muramatsu, 2007) and expanded long-term care services within the tax-based social security system.

6.7.1 Coverage

Prior to 2000, non-residential care in Japan was means-tested and provided by local authorities, whereas residential care was fully funded by healthcare insurance and provided by the healthcare sector. In 2000, Japan imple¬mented a compulsory social long-term care insurance system aiming to fully shift the responsibility for care from individuals and families to society (Campbell and Ikegami, 2000; Tsutsui and Muramatsu, 2005).

The system was designed to cover all care needs for people over the age of 65 and age-related care needs for people aged between 40 and 65 (minus a 10% co-payment). According to research by Forder and Fernandez (2011), the insurance benefits cover the total cost of care of the individual, both non-residential and residential, but the amount of benefits varies according to the assessed needs. The need assessment is conducted by a panel of professionals and, after a complicated process, produces a score, according to which the individual is placed in one of seven levels: two providing entitlement to preventative care benefits and five providing entitlement to
support benefits (Ikegami, 2010). The need assessment is carer-blind, which means that users are not discriminated against if they receive their care from a relative.

Reflecting the high initial cost of the system, since 2005, entitlement to having the costs of accommodation in residential care paid by the state has moved from universal to means-tested, only a third of the accommodation costs being universally covered. This reform was introduced to control the costs of the scheme. In addition, low-need groups are now only entitled to preventative services (such as compulsory annual checks, health education programmes, preventative rehabilitation, preventative in-home and day care services (Ono, 2011)) and not care services.

The number of all people with long-term care insurance in Japan in 2010 was 29.07 million, of which:

- 48% (14 million) were aged 75+;
- 51% (14.7 million) were aged between 65 and 75; and
- 1.3% (0.37 million) were those people aged between 40 and 65, who had an age-related disease.

### 6.7.2 Funding structure

Half of the funds necessary to cover the cost of the long-term care system are raised through general taxation, both at the national and local level. Another third of the system is funded from insurance premiums from people aged between 40 and 65, (1% of their income), and the remainder from insurance premiums from people aged above 65, which are set according to a fixed tariff of premium rates. In addition, beneficiaries contribute a co-payment of 10% of the cost of their care, which is reduced for lower-income citizens on a means-tested basis (Tsutsui and Muramatsu, 2007). Currently people below the age of 40 do not pay contributions to the system.

### 6.7.3 Uptake

Just after the introduction of the reform in 2000, the number of people receiving care benefits increased dramatically. However, by 2003 the growth rate of beneficiaries had fallen back and was evolving in line with the growth rate of the population aged 75 and above.

In 2010, 5 million people, or 17.2% of all the insured, were eligible for social care benefits in Japan. 80% of all eligible people are aged 75+. Out of all eligible people, around 80%, or 4 million, received long-term care benefits, of which:

- 97% (or 28.7 million) are people over 65 (i.e. 13.5% of all people in this age group); and
- 3% (or 120,000 people) are between the ages of 40 and 65 (i.e. 32% of the insured in this age group) (Ministry of Health, Labour and Welfare, 2010).

As reported by Forder and Fernandez (2011), 20% of those eligible to social care benefits chose not to receive benefits. The main reasons reported are the 10% co-payment required and the service-only nature of the benefits, which restricts individuals’ choices.

### 6.7.4 Cost

The Japanese long-term care system only provides in kind services, without the option for cash benefits. The residential care cost was equivalent to £1,500-£3,250 per person per month in 2009.
The home and community care cost varies with the assigned needs level. For people in need of preventative services only, the monthly cost was in the range £380-£840, and for those in need of care services, the cost ranged between £1,270 and £3,000 per month in 2009 (Forder and Fernandez, 2011).

After the social care reform in 2000, total expenditure of the system increased at a fast rate due to the increase in the number of claimants. In 2000, before the reform was implemented, total actual social care expenditure was around 3.6 trillion Yen (£21.1 billion), compared to an available budget of 4.3 trillion Yen. In contrast, in 2005, the costs of long-term care grew with an average year-on-year growth rate of 13.6%, up to around 6.8 trillion Yen (1.4% of Japan’s GDP in 2005), thus exceeding the forecasted expenditure of 5.5 trillion Yen by 1.3 trillion (Ikegami, 2010). After the structural changes in 2005, the average expenditure per person over 75 has been fairly constant (Forder and Fernandez, 2011).

The maximum cost per month for a person in non-residential care is between the equivalent of £380 and £840 for support services and £1,270 to £3,000 for care services, varying according to the need level. The maximum fees for institutional care range between the equivalent of £1500 and £3,250 per month. All service charges are set by the government and are equalised in real terms across regions (Campbell et al., 2010). Monthly benefits are only in-kind, without a cash option.

6.7.5 Advantages

Since the reform in 2000, non-governmental non-profit and for-profit providers have entered the market, the for-profit non-residential providers accounting for 44.6% of all community care providers on the market in 2005 (Ikegami, 2010). The fact that costs are nationally regulated ensures competition on quality of service. Additionally, the number of professionals providing full-time care services has doubled for the same period of time.

6.8 Australia

The Australian system of long-term care for the elderly is a means-tested system which is primarily financed through general taxation, with some co-payment contributions. Means-testing is applied to determine the level of individual co-payments (Forder and Fernandez, 2011). The system only funds in-kind services, without a cash payment option. Services are provided both from non-profit (over 80% of providers) and for-profit organisations, as well as the government and local territories. The focus of changes in the system since the 90s has been on increasing the uptake of residential care services.

The proportion of people aged 65+ in Australia in 2010 was 13% (World Bank data). The estimated year-on-year growth rate of people aged 85+ over the next 40 years is 4%, meaning that the projected increase is from 400,000 to 1,800,000 people (Aged Reform Implementation Council, 2013). In 2012, the Australian government announced a 10-year plan to reform the care system for the aged population following the influential Productivity Commission report of 2011, to address the needs of its ageing population.

6.8.1 Coverage

Different care packages exist for non-residential care services. Various Community Care (CC) packages provide high-level care for people who are eligible for residential care but prefer to remain in their home. The Home and Community Care (HACC) package, on the other hand, is
Paying for care: alternative models

LE Wales
Future of Paying for Social Care in Wales

6.8.2 Funding structure

The HACC scheme only charges users a basic hourly fee, means-tested, payable by all users and determined at the local authority level. The means-tested threshold varies between local authorities.

Other non-residential care types of providers are regulated by a nationally-set charges structure, which determines service charges according to the assessed level of need. The charges that the consumers face are means-tested, but typically, all care recipients pay 17.5% of their age pension towards the provided care package; those with income above the full pension level can be required to pay up to 50% of that additional income. It is worth noting that the total cost that a recipient pays might exceed the actual cost of their care package and thus subsidise recipients who can pay less. This often stimulates providers to pick wealthier clients (Henry Review, 2010).

The number of approvals to non-HACC community care providers is limited by the providers’ budget. The level of need of the individual is what determines the type of their care provider; once assigned to a care scheme, the providers receive a subsidy per client based on the average care cost within the relevant type of community care provider (Productivity Commission, 2011).

In residential care, public funding is only used to cover the care component, but not accommodation and everyday living costs. Daily living costs, such as meals, energy and laundry, are compulsory for all residents and cannot exceed a nationally-set maximum of 84% of the basic age pension (Productivity Commission, 2011).

The Aged Care Funding Instrument (ACFI), a complicated tool designed to capture individual circumstances, has been used since 2008 to calculate the level of subsidy payable towards individual’s care component costs. Three types of costs are included – costs that cover everyday life activities, behavioural costs and complex health care costs (Forder and Fernandez, 2011). The total public subsidy varies according to the need-based level of care received and the individual’s income, and has a ceiling of AU$162.89 per day (2011).

Accommodation charges in residential care are not publicly subsidised but are regulated by the government, so that there is a means-tested ceiling on the maximum amount providers can charge residents. Individuals start paying an accommodation charge if they are in high-level care and their income is above AU$38,500; the annual maximum they could be asked to pay for accommodation

tailored primarily to people with lower care needs which mostly include day-to-day tasks such as provision of meals, household tasks, hygiene and transportation (Productivity Commission, 2011).

Low-level residential care services incorporate accommodation and assistance with everyday tasks such as feeding and personal hygiene, whereas high-level care covers more complex social services as well as nursing and medical support.

Access to care services can be gained upon need assessment, which can be carried out by different assessment teams. They then have the authority to approve an individual to receive care services. Usually different assessment authorities are enabled to perform assessment and approve service from specific care providers. For instance, the HACC Assessment Service approves individuals to receive HACC care packages. Provision of HACC care is constrained by the budget of the specific provider, hence priority is given to individuals with highest need. The Aged Care Assessment Teams (ACATs) are comprised of health professionals who assess and approve people mostly for Community Care packages. (Productivity Commission, 2011)
is AU$10,485, which applies for income levels above AU$98,000. The average annual charge per customer paid in 2009/10 is AU$8,216. Deferred payment schemes are also available.

The government partially reimburses residential care providers for the difference in actual and charged accommodation costs. The level of reimbursement depends on the proportion of residents who are low-income, thus also encouraging providers to attract higher-income customers (Productivity Commission, 2011).

### 6.8.3 Uptake

As of 2010, over 163,000 elderly people were in residential care facilities, 70% of which used high-level services. Around 50,000 people used high-need non-residential services, and 600,000 – low-need non-residential services. Of those 600,000, only 10% received more than 2 hours of care per week. This amounts to a total of 813,000 elderly receiving social care services of any kind, which is 29% of all people aged above 65.

### 6.8.4 Cost

The total Australian government expenditure on care for the aged in 2009/10 amounted to just over AU$11 billion (or 0.9% of Australia’s 2009 GDP (OECD data)), of which AU$7.29 billion was spent on residential care services and AU$3.17 on different non-residential care packages (Forder and Fernandez, 2011).

The average total annual cost of non-residential care per recipient in 2009/10 was around AU$6,510, of which the state covered about AU$6,090 (or 95%). The average total annual cost of residential care per recipient was AU$61,460, of which AU$41,900 (68%) was born by the public purse.

### 6.8.5 Advantages

The Australian system of care for the aged is both based on the need levels and on the available budget, and high-income individuals often face the full charge of their care. However, the Australian system has a relatively high coverage and low need eligibility threshold. In the case of low-need, low-frequency care support, the client co-payments are also at a low rate (Forder and Fernandez, 2011).

### 6.9 England

The long-term social care system in England is a needs-based and means-tested system. The UK Government is responsible for policy-making, regulation and funds allocation to local authorities for long-term social care. Local authorities are responsible for implementing national policies, as well as developing local ones, and managing the spending of national and local funds for long-term care (National Audit Office, 2014).

The long-term care system in England, similarly to the rest of the UK, is challenged with continuously growing demand, decreasing public spending and an unmet need for care. Life expectancy in England has been increasing at a faster rate than disability-free life expectancy, meaning that the proportion of the population limited in their daily activities and in need of long-term care has been growing (National Audit Office, 2014 and Office for National Statistics, 2013).
Local authorities have decreased spending on long-term care by 8% between 2010 and 2013. The population segment affected the most is older adults with a 12% decrease of care, whereas younger adults with learning disabilities have experienced almost no decrease (under 1%). 75% of the total decline in care spending over the past three years is due to less care provided, which can be explained by

- effective prevention measures;
- tightened eligibility criteria - now 87% of individuals are eligible for formal care only if with “substantial” or “critical” need; or
- reduced service

The remaining 2% of decreased expenditure are attributed to local authorities paying less for care through

- reducing administrative costs;
- paying lower fees to contractors; and
- negotiating discounted prices for bulk buying

Furthermore, reducing the amount of public provision of formal care poses a negative externality effect on provision of informal care. The number of informal carers in 2011 is estimated at 5.4 million, which represents an 11% increase from 2001 – a faster rate of increase than the population growth rate. In comparison, the number of people employed in the formal care sector in 2012 is 1.5 million. Additionally, the informal carers have been, on average, increasing in age – now over 20% of them are aged 65+. Informal carers are also providing more hours of unpaid care than they used to in 2001 (National Audit Office, 2014).

### 6.9.1 Coverage

In the 2011 census, 9% of adults reported to be limited in their daily activities due to old age or a long-term condition. This proportion increases to a third for the over-65s and a half for the over-85s. Over two-thirds of adults receiving formal care services through local authorities are above the age of 65.

85% of adults above 65 live in areas where the minimum level of need to be considered eligible for formal care is “substantial”. Three local authorities, where 1% of all adults live, restrict the eligibility criteria to a minimum level of “critical need” (National Audit Office, 2014).

### 6.9.2 Funding structure

Formal adult social care services are directly or indirectly funded by user’s private funds, local authorities’ own budgets, the Department for Communities and Local Government, the Department for Work and Pensions and the Department for Health. Direct funding is in the form of payments from the local authorities and/or users. The complex funds flow is illustrated in Figure 1.
England has both a lower capital limit (after which users start contributing towards the care costs) and an upper capital limit (after which users have to fully sustain the care costs) for residential care charges. Users with capital between the two limits contribute to their service charges on a sliding scale. Currently, the lower capital limit is set at £14,250, and the upper capital limit – at £23,250. Capital limits for non-residential charges are typically the same but the property where the user lives is disregarded when computing total assets.

6.9.3 Uptake

Out of all people over 65 (8.6 million), the proportion of those in publicly supported long-term care in 2010 was 9% (780,000 people). Out of those, 170,000 people – or 2% of the population segment – were in residential care. Another 610,000 – 7.1% of the over 65s – received non-residential care services in the same year.

In comparison, less than 1.5% of all adults below the age of 65, which is around 450,000 people, received long-term care services. The majority of them (390,000) were non-residential care users. There were 60,000 younger adults in residential care in England in 2010 (Commission on Funding of Care and Support, 2011).

6.9.4 Cost

Adult social care represents 39% of local authorities’ spending, which makes it the second-largest expense after education. Public care spending rose from £8 billion in 1994/95 to £16.3 billion in 2010/11, since when it has fallen by 8%. 72% of it is on services commissioned to independent providers (National Audit Office, 2014).
The total cost of formal care services arranged by local authorities in 2012/13 was £19 billion, of which £14.6 billion are local authority contributions, £1.9 billion – NHS contributions, and £2.5 billion – user contributions. The cost of self-funded care is not included. It has been estimated to represent another £10 billion for 2010/11. Informal cost represents the largest proportion of the value of social care, estimated to be as high as £97 billion per year (National Audit Office, 2014).

Forder (2007) estimated that 37% of residential care users aged 65 and above in England in 2006 were fully self-funded, 41% relied only on LA funded care, and a further 22% privately topped up on LA funded care. For non-residential care services, the proportion of users privately contributing towards the entire care costs was estimated to be around 19%, those fully covered by the LA were 60% and 21% combined LA funding with privately purchased care services. The Institute of Public Care (2011) estimated an increase in the proportion of self-funded residential care - up to around 45% of residential care users were fully self-funded in England in 2011, compared to 37% in 2007. This implies an increasing cost of self-funded residential care.

<table>
<thead>
<tr>
<th>Study</th>
<th>Coverage</th>
<th>Type</th>
<th>% self-funded</th>
<th>% topping-up on LA funded care</th>
<th>% funded by LA (no private top-up)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forder (2007)</td>
<td>England</td>
<td>Residential care</td>
<td>37%</td>
<td>22%</td>
<td>41%</td>
</tr>
<tr>
<td>Forder (2007)</td>
<td>England</td>
<td>Non-residential care</td>
<td>19%</td>
<td>21%</td>
<td>60%</td>
</tr>
<tr>
<td>IPC (2011)</td>
<td>England</td>
<td>Residential Care</td>
<td>45%</td>
<td>55%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Forder (2007), Institute of Public Care (2011) and Laing and Buisson (2013)

The proportion of self-funders varies vary with income and assets and so there is typically a high regional variation with a higher proportion of residents in more affluent areas relying on personal resources to fund their own care. Similarly, there is considerable regional variation in the cost of residential and non-residential services provided across the country: estimates by Laing and Buisson for 2011/12 showed that average annual fees for residential care homes can vary from just above £24,000 (in Yorkshire & Humber, North East and North West) to over £30,000 (London and the South East).

6.9.5 Long-term social care reform: the Care Bill

Currently, the probability of an individual needing long-term social care if they are aged 65 or above is 20%, and this probability is growing. A significant proportion of care users lose most of their assets and life savings to funding their care (The Chartered Insurance Institute, 2013). At the same time, lack of trust and confidence, as well as other entry-level barriers has resulted in a low take-up of financial products and instruments designed to fund long-term care. There is a growing need of good-quality care services, the sustainable provision of which is likely to require a substantial private market involvement.

To address the increasing pressure on social care, the UK Government has introduced the Care Bill, which is currently being reviewed in Parliament and is expected to be implemented up to 2016. This new piece of legislation follows the influential Dilnot Review from 2011. The Care Bill is enforceable in England only, however it is expected to have some impact on future care policy changes in the devolved countries.

The Dilnot Commission (2011) reviewed the market for long-term care in England up to date and recommended the following reforms:
a nation-wide needs assessment framework to ensure consistency and portability of assessment between local authorities;

- a ceiling of the total individual lifetime care costs set between £35,000 and £50,000. According to Dilnot, such limit is likely to stimulate a market for private insurance;

- an increased upper limit of the means-test from £23,250 to £100,000. It is suggested that up to that limit, people should receive support, and above that limit, they should pay for everything themselves; and

- a wide implementation of a deferred payments scheme.

The Care Commission report was followed by the publishing of a White Paper and a public consultation. As a result, the Care Bill has been redrafted and is currently discussed in Parliament for final amendments. The most notable provisions the Care Bill introduces are:

- a secured access to advice on care for all users and support for their carers, including financial advice on meeting private costs of care. It will be the local authorities’ responsibility to provide users with impartial guidance on how to access the most appropriate for them form of care, as well as to sign-post them to sources of information on how to manage their finances in relation to funding their care.

- a unified eligibility criteria across local authorities – the universal eligibility threshold for users to be entitled to arranged formal care services will be set at “substantial need” level. This policy ensures that there is no more “postcode lottery” discrimination and the probability of receiving supported care will be independent of their residence location. A cap on the cost a person would pay to cover their care needs over their lifetime (The Care Bill, 2013). Currently the cap is set in the 2016 budget to £72,000, which includes charges for both non-residential care services and the care component of residential care services, but not for accommodation;

- an increase in the upper capital limit to the level of £118,000 as of April 2016.

Different stakeholders have expressed concern that the policies proposed in the Bill may not be sufficient to mitigate the growing pressures on the care system (National Audit Office, 2014).

6.10 Scotland

The Scottish demographic picture is similar to the one in England and the rest of the UK. People aged above 65 accounted for 16.8% of Scotland’s population in 2010, and those aged 75+ represented 7.8% of the population. The 2035 proportion of people above 65 is forecasted to grow by 48%, up to 24.9% of the population; the proportion of those aged 75+ is expected to grow even faster, by 64%, to a level of 12.8% of all people in Scotland (Elliot et al, 2012).

The adult long-term care system in Scotland shares most of its core characteristics with the systems in the rest of the UK. Its distinctive characteristic is the entitlement to free personal care for over-65s, both in a domiciliary and care home setting, subject to eligibility. The idea behind free personal care is to eliminate discrimination against older people with long-term conditions (Vestri, 2007). As discussed by Elliot et al (2012), the system is considered particularly successful in shifting demand from residential to domiciliary care. However, there has been some criticism towards the regional variation in the interpretation and implementation of the free personal care guidelines, as well as towards the lack of awareness of long waiting times (Vestri, 2007).
6.10.1 Coverage

For all people above the age of 65, personal care payments contribute towards the cost of the care component in residential care. These payments are universal, not means-tested. Additionally, the state, as elsewhere in the UK, provides nursing care payments for everyone in need of nursing care, regardless of their age or income. In 2012/13, the value of payments was:

- £163 per week for personal care in a care home;
- £74 per week for nursing care; and
- £237 per week if the user is in need of both personal and nursing care.

These amounts provided by the local authorities are payable upon a contractual agreement between the user and a care home (Elliot et al, 2012).

6.10.2 Funding structure

Non-residential care

So far in Scotland there has not been a lifetime or a weekly cap on care costs in place, however personal home care for users aged 65+ is free of charge. This includes services related to feeding, personal hygiene, etc., but not domestic help. Charges on help with household duties, laundry and shopping are subject to the standard income assessment.

Residential care

For individuals aged 65 and above, charges for the care component of residential care are covered by the personal care payments, regardless of their means. This implies that even people who fail the means assessment also receive care top-ups and only have to fully fund their accommodation costs. Accommodation charges are means-tested. The means-testing principle is similar to the one in England: the capital threshold above which users pay the standard rate for care is £25,250. Between £15,500 and £25,250, their contribution is calculated depending on capital levels, and below the floor level of £15,500, users are not required to make any contributions towards their care from their capital but, will be required to contribute from their eligible income. The income assessment for residential care typically takes into account income from state or private pensions, some of the savings credit and the value of the person’s home unless any dependents share the same home. There is a personal allowance currently at the level of £23.90 per week which is excluded from the income assessment.

Deferred payment schemes

Since 2002, residential care users have been entitled to opt for a deferred payment scheme to postpone selling their homes during their lifetime. Deferred payments are nationally regulated by the Scottish Government and operated by local authorities.

6.10.3 Uptake

Around 5.9% (or 51,800) of all people above the age of 65 received home care in Scotland in the 2010/11 financial year. 90% of them received personal care services, for which local authorities do not charge. This represents a 42% increase in uptake from 2003/04, which is partially due to the increasingly aged population, and partially – to the encouragement for people needing care to remain in their homes (Elliot et al, 2012).
In 2011/12, only around 30,600 people above 65 – 3.5% of the population segment - were in residential care homes in Scotland, which represents a 4% decrease from 2003/04. There has been a nearly 20% increase in the residential care recipients of free personal and/or nursing care payments since this allowance was introduced in 2002, which in 2012 amounted to 9,700 people.

### 6.10.4 Cost

In 2010/11, the cost of home care for recipients above the age of 65+ amounted to £406.7 million, 37.7% of which were spent on personal care services. Residential care expenditure for people above the age of 65 was around £627 million in 2010/11, with average annual fee for residential care services of £29,000 (2011/12 levels). In total, long-term social care for the elderly cost £1.03 billion in 2010/11 (Elliot et al, 2012).

Since 2000, there has been a growing effort towards integrating social and health care, especially for older people and people with long-term conditions. Such initiatives include the restructuring of management and funding of various bodies (Ham et al, 2013). The Change Fund has been established with the purpose of rebalancing services from health and residential social care to home-based services which enable users to remain in their homes. Over the past three financial years, a total of £220 million have been allocated to the fund. The fund is planned to close in 2015.

One direction towards empowerment of the user is the Social Care Self-directed Support (Scotland) Act from 2013, which requires local authorities to provide users with a range of care delivery options, so as to allow them to decide how much control and responsibility towards their own care they would like to take on. Under the Act, local authorities are also obliged to provide users with information and advice, and allowed to provide their carers - with support (Ham et al, 2013).

Another particularly successful feature of the Scottish care system is the Telecare service – Scotland has been recognised as the champion of Telecare integration by the European commission (The King’s Fund, 2013). It has the potential to assist integration of healthcare and social care for people of age and with long-term conditions by enabling them to live at home independently and manage their own care.

The efforts of integrating healthcare and social care have so far helped contain the demand for emergency and acute care services amongst the people with long-term care needs (Ham et al, 2013).

### 6.11 Northern Ireland

The population of Northern Ireland is projected to grow by 8% from 1.8 million in 2010 to 2 million in 2025. Within the same period, the population segment of people above the age of 65 is expected to increase by 42% (from 260,000 to 370,000), and that of people above 85 – by 120% (from 25,000 to 55,000) (Ham et al, 2013). Although currently Northern Ireland has a younger-than-average population than elsewhere in the UK, demand for adult long-term care is expected to substantially increase, partially due to lower levels of health and well-being of the population than in other UK countries (Bell, 2010).

#### 6.11.1 Funding structure

The social care system in Northern Ireland differs from those in other UK countries primarily due to the fact that its social and health care systems have been integrated since 1973, and are jointly
provided by five Health and Social Care Trusts (Gray and Horgan, 2010 and UKHCA, 2013). The Health and Social Care (Reform) Act (Northern Ireland) from 2009 further reduced the administrative burden on both health and social care delivery.

Another distinctive characteristic of the way the Northern Irish long-term care system operates is that even though local authorities have the power to charge for non-residential care services, they do not normally do so (Alzheimer’s Society, 2013). Two exceptions to this are charges made for:

- The ‘home help’ scheme – charges for this service are made on a means-tested basis; and
- the provision of meals on wheels, which is a flat-fee service.

Similarly to the residential care funding system in England, the one in Northern Ireland has both a lower and an upper capital limit. Users whose funds are below the lower limit have their residential care fully covered by the local authority but will be required to contribute from their eligible income and those with capital between the two limits contribute to their service charges on a sliding scale. Those with assets above the upper limit fully fund their own residential care. Current lower capital limits for residential care charges are set at £14,250, and upper capital limits at £23,250.

6.11.2 Uptake

In September 2012, the number of publicly-funded home care service users was estimated at 24,150. Of those, 82% were above the age of 65. (UKCHA, 2013). They used around 160,000 hours a week, 64% of which were provided by the independent sector. Over the past ten years, the proportion of people in receipt of domiciliary care has increased by a third, yet spending on low-level-of-need services has reduced. This suggests a shift of demand for high-need services from residential to non-residential care. Close to 8,000 people were in receipt of intensive home care services.

6.11.3 Cost

Care for the elderly in 2007/08 accounted for £645 million, a quarter of which was spent on nursing homes. Between 2002/03 and 2005/06, the expenditure on non-residential care services has grown by 40%. In 2011, this was £200 million (UKCHA, 2013).

The average annual fee per person for residential care homes in Northern Ireland in 2011/12 was just above £24,000. Northern Ireland has the largest number of residential care beds per person above 65 in the UK. This might be partially due to the higher level of people with disabilities and high-level needs, however authorities such as the Northern Ireland Audit Office (2008) recommend further efforts to shift demand towards home care, and expenditure towards lower-level need and preventative services (Gray and Horgan, 2010).

The health and social care services system is in the process of being transformed in Northern Ireland, due to the pressures on the system and the growing ageing population (Elliot et al, 2012). An expert review commission was assembled in 2011 to investigate potential changes to the care model. In 2011, the Compton Review was published, which identified an unmet need for preventative integrated care for long-term conditions (Ham et al, 2013). As a result of the review, there is a commitment in Northern Ireland to shift spending from high-need care to preventative, tele- and home care.
The proposed model was centred around the individual, and the key recommendations on adult long-term care are:

- encouragement of the dependent to receive care in their own home for as long as possible, thus reducing residential accommodation;
- delivery of better-integrated care;
- higher implementation of technology in the care sector;
- a more varied provision of care services;
- empowerment of users to shape the care they receive according to their needs and preferences and to control their budget;
- and a higher participation of the independent sectors in the provision of care; and
- more practical support for carers.

Insufficient evidence on the efficiency of the social care system, which is overshadowed by healthcare, makes it difficult to assess the effectiveness of any changes made in the care market in Northern Ireland.
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