

Dartington review on the
future of adult social care:
*What can England learn
from the experiences
of other countries?*

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Introduction

This paper discusses the future funding, organisation and delivery of adult social care by drawing on the experiences of other advanced welfare states, both in Europe and further afield. These issues are of major topical importance. In May 2008 the English Government announced a period of consultation on the future funding and delivery of care and support for disabled adults and older people (Department of Health, 2008). A year later, in July 2009, a Green Paper was published; this proposed a number of potentially radical changes to adult social care (HM Government, 2009) and a further period of consultation was announced. However, these debates are also much longer standing. They were reflected in the establishment of a Royal Commission over a decade ago (Royal Commission, 1999) and the Wanless Review (Wanless, 2006) into the future demand for and costs of care for older people. Despite robust projections of demographic change, particularly future population ageing (HM Government, 2009), this long history and on-going consultation on options suggests that politically acceptable and economically sustainable solutions are proving hard to find. How have other countries tackled these challenges?

It cannot be assumed that arrangements that appear to work well in one country or jurisdiction simply provide a blueprint for reform in England. Patterns of social care services tend to be deeply embedded in the distinctive historical and legal traditions of individual countries. They are built on primary legislative and constitutional arrangements and reflect distinctive historical trajectories of welfare state formation and development. In federal states, where local and regional governments have considerable autonomy, patterns of social care provision may vary widely within the country, as well as between countries. Consequently, reforms in social care generally build incrementally on existing institutional arrangements, rather than borrowing wholesale from models of other countries (Karlsson et al, 2007). Despite this tendency, radical reforms that break with traditional institutional and cultural arrangements are nevertheless possible, as will be illustrated below.

Within individual countries cultural attitudes towards the roles of families, and expectations about the roles of women in particular, further shape patterns of social care and the scope of formally organised services (Lewis, 1992). Moreover, a focus only on state policies and structures can obscure the roles played by important regional and local care providers such as private charities, church and other non-governmental organisations, not just in delivering services, but in shaping overall patterns of provision (Bettio and Plantenga, 2004). These diverse social and cultural factors mean that there is often little relationship between the age structure of a country's population and its consequent demand for care, and actual levels of spending on care services measured as a percentage of national Gross Domestic Product.

Despite these difficulties, valuable insights and lessons for reform, both positive and negative, can be derived from the experiences of other countries. Rather than starting from the organisational arrangements that we are familiar with, evidence from other countries can open up for examination a wider range of options on which the funding, organisation and delivery of services could be based. In particular, evidence from other countries can reveal very different sets of values, assumptions and principles that underpin the funding, organisation and delivery of social care and thus prompt fundamental questions about the principles on which future reform in England should be based. Evidence from other countries can also shed light on the potential political and social factors that could constrain or facilitate implementation of new reforms. Finally, evidence from elsewhere can highlight additional, complementary measures that might be required to achieve desired policy objectives.

Rather than taking a country-by-country approach, this paper considers five key issues: universal vs targeted social care provision; equity; choice and the provision of social care in the form of cash or services; the roles of and support for family carers; and longer-term economic and political sustainability. Each issue will be illustrated with examples from different countries and, where appropriate, the implications for reform in England will be highlighted.

Universal or targeted social care?

England is relatively unusual in international terms, in that access to publicly funded social care and support is restricted to those who have both high levels of need, as measured by Fair Access to Care Services (FACS) criteria, and who also have very low levels of assets and incomes. People with resources (including housing) over £23,000 cannot access publicly-funded social care, however great their needs for support. Despite the national assessment framework provided by FACS, its application varies between local authorities depending on the resources available locally. Access to other social care services and resources (including the Independent Living Fund, NHS-funded continuing care and housing-based support) depends on a complex range of eligibility criteria that variously take into account medical and nursing care needs; capacity for self-care; risks of harm; financial circumstances; and the availability of informal care (Glendinning, 2007).

The unpopularity of this local 'postcode lottery' was recognised in the 2009 Green Paper proposal to establish a National Care Service, under which everyone would receive a consistent service regardless of where they live. However, the Green Paper did not go so far as to make a commitment to universal social care arrangements, accessible to all regardless of income, assets or age. Indeed, it actually introduced new divisions by proposing different arrangements for younger and older disabled people.

By contrast, a commitment to the principle of universality – equal access to social care by both affluent and poorer, younger and older people – is the striking feature of many other countries' approaches to care. Universalist principles assume that a need for substantial levels of support or care – whatever the cause, the age or the financial situation of the individual - is a normal risk of life for which society as a whole should make provision. Most individuals are unable to meet such extra needs from their own resources, without impoverishing themselves or their families. Universal access to publicly-funded social care provides protection against such catastrophic consequences and helps ensure social inclusion for all who need social care, regardless of their means (Brodsky et al, 2000; Brodsky et al, 2003; Gibson et al, 2003).

Only in the US does Medicare exclude from publicly-funded care older people with assets above a prescribed level. Australia also published proposals in 1997 to charge a substantial lump sum entry fee on admission to nursing homes that would inevitably have involved the sale of a house. Following strong opposition the proposal was dropped and in 1998 the alternative option of paying a higher means-tested daily accommodation charge was introduced instead (though in practice, longer-term residents are still often faced with having to sell their homes in order to afford the fees).

In contrast, in many other countries access to social care depends only on an assessment of the level of disability or the help that is needed, regardless of means or assets.

Universal access to social care regardless of income or assets

Germany's long-term care insurance scheme provides benefits for severely disabled people of all ages, regardless of their income or assets. One of the reasons behind the introduction of the scheme in 1994 was the stigma experienced by older people who had to 'spend down' their assets in order to qualify for means-tested social assistance to help pay the costs of institutional care. Membership of a care insurance scheme is compulsory, with almost the entire population now covered. Indeed the scheme is popularly known as *Volksversicherung* – 'people's insurance'.

In Austria, a cash Care Allowance funded from taxation was introduced in 1993. It is paid at one of seven levels, which are determined solely by the amount of help needed and regardless of income or assets. The Care Allowance can be used to pay for care at home or in an institution.

Danish social services are the responsibility of local municipalities. All services are free of charge, regardless of the number of hours care received or the income of the recipient. In nursing homes, user fees are levied only on services for which commercial charges would normally be paid, such as rent, laundry, meals and hairdressing.

Universal access to social care in most countries is determined by a single assessment of eligibility – whether this is carried out by a care worker from the local municipality, a national body or an agency working on behalf of a social insurance scheme. In Germany, eligibility for long-term care insurance is determined by a standard, nationally-applicable assessment of the amount of help needed in four areas of daily living – personal hygiene, eating, mobility and housekeeping. Claims are assessed by medical boards on behalf of the care insurance funds and the amount and frequency of help needed determines the level of benefit payable, at one of three 'care dependency' levels.

In England, such standardised assessment processes are more commonly associated with cash social security benefits such as Attendance or Disability Living Allowance. However, they can also assess eligibility for packages of in-kind care services up to a specified value, depending on the assessed level of disability or care needed, either as the only option (as in France and Japan) or as an alternative to cash payments (as in Germany).

As well as providing equal access to people with greater or fewer assets, or higher or lower incomes, universal arrangements also offer equal access and similar levels of provision to people of all ages. The social insurance schemes that support social care

in Germany and the Netherlands cover working age and older people and disabled children, as do municipal home help and home nursing services in Denmark. In contrast, the experiences of Australia and Japan illustrate the substantial inequalities and subsequent difficulties that can arise from social care schemes developed specifically for older people. In Australia in the 1980s, the Commonwealth Government's Aged Care Reform Programme was remarkably successful in limiting the growth of expenditure on nursing homes and encouraging the development of alternative home and community-based services for older people. Reforms included the establishment of specialist multi-disciplinary assessment teams and specialist care management initiatives, as well as stimulating a wider range of responsive community services. However, recently there has been mounting concern about the chronically under-funded and severe shortage of specialist and rehabilitation services for younger disabled adults. These shortages often mean that young adults, particularly with complex or severe needs, are inappropriately admitted to residential and end-of-life care facilities intended primarily for older people. A major public enquiry conducted in 2006-7 by the Australian Senate called for a National Disability Strategy and co-ordinated policies to address the needs of working age disabled people and their families. New funding of A\$1.8 billion announced in 2008 was the first step in this Strategy and will fund improvements in domiciliary, respite and supported accommodation services. Similarly, in Japan long-term care insurance benefits are generally only available to older people; however the equity of this arrangement is now being questioned (see below).

In this respect, the proposals in the 2009 English Green Paper risk introducing new divisions between younger and older disabled people, by proposing a free care system for people of working age alongside care arrangements for older people that would be funded partly from taxation and partly from the optional or compulsory insurance contributions of older people. Further new divisions would be introduced by the Green Paper's proposals to treat Attendance Allowance (received by older people) differently from Disability Living Allowance (mainly received by younger disabled people).

It is, of course, perfectly possible for universal social care arrangements that are available to everyone regardless of income or assets to be combined with principles of fairness, so that those who can afford to contribute to their care do so. User charges bring in useful revenue and hence contribute to the economic sustainability of social care provision. They also help to ensure political sustainability, by reducing arguments that those who could afford to pay for their own social care are receiving it free of charge. In France, for example, the nation-wide, universal *Allocation Personnalisée d'Autonomie* is awarded to fund service provision at one of six levels of dependency. People with incomes below a minimum threshold pay no charges; people with incomes above this level pay charges according to their income.

Japan's long-term care insurance scheme

Everyone aged 65-plus is eligible for benefits, as are people aged 40+ suffering from age-related disabling conditions (e.g. Parkinson's Disease). There are transparent, nationally-uniform eligibility criteria; income, assets or the availability of family care are not taken into account. Municipal officials administer a 79-item questionnaire about activities of daily living and answers are scored using a computer algorithm to create seven levels of need; these determine the level of benefits. Benefits are provided in the form of services – institutional care, home help, nursing and bathing services, day care and respite care, equipment and adaptations (Campbell and Ikegami, 2003). All beneficiaries are expected to contribute a standard ten per cent charge, regardless of income, but with subsidies for poorer older people. However there are arguments that the standard charge may deter lower-income people from applying for the social care they are entitled to; others may simply reduce their level of services by not making the ten per cent contribution (Izuhara, 2003).

Equity

A commitment to universal principles – equal conditions of access to all – is a prerequisite for equity. Equity has a number of dimensions, each of which constitutes an important underpinning principle.

First there is diagnostic equity – the principle that people with similar levels of impairment are treated equally, regardless of medical condition or the reason for needing social care. This principle is partly compromised in England, because people who need substantial amount of care because of dementia are less likely than those with on-going physical health problems to qualify for fully funded NHS continuing care (including the costs of all social care needed). In contrast, older people with dementia are more likely to encounter the test of assets determining their access to publicly-funded social care and/or pay means-tested charges for domiciliary services.

Diagnostic equity is not always easy to achieve and crucially depends on the nature of the assessment used to determine eligibility for social care. In Germany, the assessment of eligibility for long-term care has long been criticised for its bias towards people with physical impairments that restrict them in performing activities of daily living. However, rather than altering the standard national assessment and eligibility criteria, in 2002 an additional benefit was introduced for people who qualified for care insurance and needed intensive, 24-hour care because of dementia; this was intended to be spent on respite care. In 2008 the level of this additional benefit was increased and the eligibility criteria were relaxed so the payment can now be claimed even if the claimant does not reach the lowest level of 'care dependency' to qualify for care insurance. In Japan, the computer algorithm used to determine the level of insurance

benefit was adjusted during the first two years of the new long-term care insurance scheme in response to criticisms that people with cognitive impairments were assessed as needing less care than those with physical impairments.

A second aspect of equity is spatial equity – the principle that people with similar levels of care needs are treated equally and allocated similar levels of social care resources, regardless of where they live. This is not the case in England, where local FACS eligibility thresholds are determined according to local resources. Local variations in access to and levels of service are also politically unpopular; the 2009 Green Paper aimed to address this through its proposals for a National Care Service. However, although the Green Paper proposed the right to have care and support needs assessed in the same way regardless of location, it stopped short of guaranteeing the same level of social care services wherever people live.

In other countries, local variations in access to and levels of social care have also been perceived as deeply inequitable and this unfairness has been a major driver of reform, even involving constitutional challenges to the traditional autonomy of local provinces and regions. In Austria during the 1980s there were marked regional differences in social services, with virtually no services in some provinces. The introduction of a national, comprehensive Care Allowance in 1993 required a state treaty between the federal and provincial governments, setting out their respective responsibilities for funding and providing services. In Japan too, the introduction of a compulsory, public long-term care insurance programme in 2000 was partly prompted by widespread concerns about previous highly variable and discretionary local decision-making and great importance was attached to the introduction of transparent, nationally standard eligibility criteria.

Denmark has a rather different approach that combines universalist approaches to social care service provision with continuing local autonomy. Central government sets the legislative framework; under the 1972 Social Services Act municipalities are required to offer domiciliary services to anyone unable to perform regular activities of daily living, with the aims of enabling them to stay in their own home for as long as possible and preventing further deterioration in physical and mental health. Local municipalities are responsible for deciding how to allocate resources between different services and for allocating help according to individual assessments of need. There is no formal eligibility threshold and the legislative requirement to provide domiciliary care according to an individual's needs is open to local interpretation (Doyle and Timonen, 2007). There is nevertheless a widely accepted principle that everyone living in the same municipality should be treated equally and have equal access to services.

A third dimension of equity is intergenerational equity – the principle that the costs of social care do not fall disproportionately on one generation, nor are the benefits of social care provision enjoyed disproportionately by one generation at the expense of others. This is a challenge in situations as at present where the cohort of older people, and consequently demands for care, are growing faster than the working age

population and it has led in some countries to adjustments of the respective financial contributions of working age and older people. Thus since 2004 retired people in Germany have been required to pay their long-term care insurance contributions in full, rather than these being subsidised by the pension insurance funds (to which working age people make major contributions).

Challenges of intergenerational equity in Japan

Intergenerational inequity is a major issue in Japan, where long-term care insurance contributions are payable by everyone from age 40. Because of their higher incomes, people aged 40-65 contribute double the level of premiums as those aged 65-plus. However, because only 45-60-year olds with age-related disabilities can claim long-term care insurance, this group receives only four per cent of benefits. Moreover, half the long-term care insurance scheme is funded from general taxation, to which those under 40 also contribute but are not eligible for benefits. These age restrictions are under review. However, any extension of the scheme to younger age groups would also require major revisions to the computer algorithm that calculates eligibility and levels of entitlement, as this has been designed for older people.

The English Green Paper proposals recognise the challenges of achieving intergenerational equity. Only a quarter to a third of care costs would be met from general taxation, to which working age people contribute disproportionately. The remaining costs would be funded from an optional or comprehensive social insurance scheme, to which only people aged 65-plus would contribute. The option of fully funding social care from taxation is ruled out because of the burden it would place on the current working age population.

Promoting quality and choice – cash or services?

While there is widespread interest in cash alternatives to social care services in kind, the reasons behind this interest varies. In countries where levels of services are very low or very limited in variety, cash payments may aim to stimulate service providers. People needing social care are expected to use the payment to purchase services from the provider that best meets their needs and preferences; it is assumed that providers will therefore be incentivised to compete for the business of cash payment holders by developing the range and quality of their services (Pavolini and Ranci, 2008). In Valencia, the introduction of vouchers for nursing home care aimed, among other things, to increase the supply of publicly-funded rooms and improve equality of access (Tortosa and Granell, 2002). In Finland, vouchers for home care services are also intended to increase numbers of domiciliary care agencies (Timonen et al, 2007).

Where services are under-developed, cash payments can also help to support the social care provided by families. This rationale underpins the choice available to people who are eligible for German long-term care insurance, to receive their benefits in the form of a cash payment or as services in kind. Although the level of the cash payment is considerably lower than the value of the in-kind service option, the cash payment has consistently proved more popular, with around three quarters of beneficiaries choosing the cash option (although there have been recent small increases in people opting for in-kind services or mixed awards of cash and services). However, where cash payments support family care, pressures on formal service providers to increase the volume, range and quality of services can be seriously reduced. Thus in Germany, despite the additional long-term care insurance payments available for people with cognitive impairments, only a small minority of the 12,300 registered providers of community services offer basic services to people with dementia. The Austrian Care Allowance was also intended to stimulate the supply of care services, but has largely failed in this aim. Because of its low level, compared to the costs of services, older people choose more rather than less informal care, using formal services only as a supplement to informal care (Kreimer, 2006). In Italy, care allowances have stimulated increases in informal and 'grey' care-giving labour, particularly from migrant workers who are employed by families at below market rates to provide live-in care to older people (Bettio et al, 2006); formal services remain wholly underdeveloped.

England is committed to an expansion of personal budgets to everyone eligible for adult social care by 2011 (HM Government, 2007). There are no restrictions on how personal budgets can be spent; the expectation is that increasing numbers of people will take these in the form of cash direct payments and spend them on purchasing care and support from directly-hired employees, family and friends and mainstream commercial services. This may have the effect of reducing market pressures on formal social care service providers to improve the responsiveness, flexibility and quality of services. It also increases the market risks experienced by potential new entrants or existing providers considering expanding into new areas of service provision

(Baxter et al, 2008). Considerable support is likely to be required from local authorities to help providers of formal social care services respond to these new market situations.

The option of cash payments instead of social care services can also be a response to consumerist demands from younger disabled people in particular for greater choice, including the choice to recruit and employ care workers privately.

Personal budgets in the Netherlands

Social care in the Netherlands is funded through the AWBZ social insurance scheme. Partly because of labour shortages in formal care service provision that led to long waiting lists for services, cash personal budgets were introduced in 1995. These are similar to English direct payments and are calculated according to the number of hours care needed, but with a standard 25 per cent deduction on the grounds that independent and informal care does not incur the same overheads as formal service provider agencies. Income-related charges are required from users; however most budget holders do not pay these but simply purchase less care than they are assessed as needing.

Personal budgets can be used to fund home nursing as well as personal care, in line with needs identified at assessment. Unlike English direct payments, they can be used to employ close relatives, including spouses; this option is particularly popular with older people, although overall older people are less likely to opt for a personal budget than younger disabled people. About a third of budget-holders employ relatives to provide care; a third purchase care from formal service agencies and a third use a combination (Da Roit and Le Bihan, 2008).

However, offering cash payments is not the only way of offering choice to social care service users. People qualifying for long-term care insurance schemes in Germany, Japan and the Netherlands are able to choose between different service providers, subject to local availability. In Japan older people are reported to try several providers before they find one they are satisfied with and community-based providers actively compete for users. As the prices of services are fixed by the insurance scheme, marketing materials focus on promoting the quality of services.

'Free choice' reforms in Denmark

Municipalities remain responsible for social care and nursing assessments and all social care services are free of charge to users. Since 2002, service users have been able to choose between providers of domestic services (housework, shopping and cleaning). In 2003 this was extended to the provision of personal care services and may be extended to equipment and housing adaptations in the future. Municipal services now compete with new, private service providers. However, the availability of choice varies, with far fewer providers, particularly those offering personal care, in rural areas. Public attitudes have shifted markedly in favour of free choice of provider since 2003 (Rostgaard and Thorgaard, 2007). Moreover, users of private services are significantly more likely than users of municipal services to report satisfaction (though this may partly reflect the much more complex care typically needed by those who choose municipal services).

Increasing the opportunities for users to choose between different service providers and for service providers to compete with each other for the business of older and disabled people needing care and support are common features of social care reforms in many countries, particularly where services are traditionally very underdeveloped or have been dominated by municipal or other monopoly suppliers. However, evidence from across Europe indicates there are major challenges in encouraging new service providers into rural or sparsely populated areas (Glendinning, 2009). Moreover, while competition between providers may help to drive up quality, there is no evidence that it drives down costs; on the contrary, for a number of reasons, overall costs may actually rise.

Family and informal care

The help provided by families (and to a much lesser extent neighbours and friends) is by far the largest source of care and support in all countries, developed and less developed. Across the 27 countries of the European Union, there were an estimated 19 million carers in 2005, of whom over nine million provided more than 35 hours a week care. By 2030 these carers are expected to increase to 21 and 11 million respectively. Family care contributes immeasurably to the sustainability of formal social care services. In countries where families are assumed to be primarily responsible for the care of older or disabled people, fewer resources are available for formal services, thus placing greater burdens on family carers and often taking their input for granted. However, across Europe there is also widespread evidence of the adverse health, well-being and financial consequences of family care-giving, whether for older or younger disabled people (Glendinning et al, 2009).

In England, assessments for social care support take into account whether informal care is available; disabled and older people with heavily-involved informal carers are less likely to receive services. As described above, eligibility and assessment processes in many other countries, with widely different approaches to social care – including Japan, Austria, Germany and France – do not take into account the availability of family carers; only the level of disability or help needed by the older or disabled person that is considered. In Denmark, assessments for social care take into account the capacity of a partner to provide practical domestic help, but not the availability of adult children or other family members outside the household while the provision of personal care remains a municipal responsibility. However, in the Netherlands, financial pressures on the AWBZ social insurance scheme have recently led the centralised board overseeing assessments to spell out the 'customary care' that family members are expected to provide.

Customary care from families in the Netherlands

'The AWBZ expects members of the same household to care for one another... We call this 'usual care'. In the case of 'usual care' you are not eligible for care paid for by the AWBZ... When you need short term care, in the first instance we assume that your partner will help you with daily care such as eating drinking, washing and dressing. When the care lasts longer than three months, we call it family care. You are eligible for AWBZ care when family care withdraws... As long as the family carer is willing to continue giving care on a voluntary basis, there is no necessity for professional AWBZ[-funded] care.'

(Central Assessment Centre Guidance, translated and cited in Tjadens, 2008)

In other countries, support for family care-giving is built into the design of social care arrangements, albeit in radically different ways. As described above, the German care insurance cash payment option was always intended to support family care and is accompanied by a range of measures to support care-giving relatives. These include additional payments covering four weeks respite each year; payments for substitute care if the carer is ill; and payment of the pension and accident insurance contributions of family carers who are employed for less than 30 hours and provide at least 14 hours care a week. Carers are also offered nursing courses and retraining opportunities if they return to paid employment. Further measures introduced in 2008 included unpaid leave from paid work for up to six months (with the care insurance scheme covering the carer's pension contributions); and rights to unpaid leave from work for up to ten consecutive days at short notice.

In Germany, access to these extensive measures to support carers are secondary rights that depend first on the older or disabled person being eligible for long-term care insurance. In contrast, in Australia, carers can enjoy an extensive range of concessionary rates for State and local municipal services, plus a two-tier system of cash benefits to which they are entitled in their own right. A means-tested Carer Payment is available to working age carers who are unable to take paid work because of their care responsibilities; this is similar to the Carers Allowance in the UK. In addition, the Australian Carer Allowance is paid to all carers supporting someone at home, to cover the extra costs of caring. It is a universal benefit, not dependent on the carer's income or assets, not taxable and unaffected should the carer leave or re-enter the labour market (Howe, 2001). A carer can receive Carer Allowance for each person they care for (but only one Carer Payment to replace lost income).

The Netherlands 'Compliment for Carers'

This payment was introduced in 2007. All carers supporting someone who is eligible for help from the AWBZ long-term care insurance scheme can receive the Compliment, which is worth €250, tax free. In its first year, only ten per cent of those thought to be eligible applied – though in fact it was the insurance beneficiary (not the carer) who had to undergo a lengthy and bureaucratic application process. Eligibility criteria have therefore been relaxed (Vijfvinkel et al, 2008).

The form in which social care is provided can have dramatically different impacts on carers. As noted above, cash payments can provide incentives to begin, or continue, providing family care, particularly where formal social care services are in short supply. There is evidence from the Netherlands and Flanders that a personal budget alternative to services in kind can bring new family members into care-giving roles. However, relatives employed in this way can also experience increased obligations,

difficulties negotiating boundaries to their care responsibilities, and are very vulnerable should the relationship with their employing relative break down (Breda et al, 2006).

Moreover, if cash payments to support family care-giving are an alternative to formal social care services, the pressures and burdens on carers correspondingly increase, as do threats to the quality of the care they provide. This risk was explicitly acknowledged in public debates preceding the introduction of long-term care insurance in Japan, where older people traditionally depended primarily on the unpaid help of daughters-in-law. Among the aims of the insurance scheme were the 'socialisation of care' (Campbell and Ikegami, 2003) and a reduction in the burdens experienced by families, but achieving these goals depended crucially on the form in which insurance benefits were paid.

Cash vs care – the impact on informal care in Japan

Some argued that insurance benefits should be in the form of a cash allowance, as this would:

- Maximise consumer choice
- Recognise and reward the contribution of family carers
- Avoid poor quality care from strangers
- Be less expensive because family care-giving has no overhead costs.

Others argued that insurance benefits should be in the form of services because cash payments:

- Would inhibit demand for, and supply of, services
- Prolong oppressive patterns of care-giving by daughters-in-law
- Prolong poor quality family care, because professional services can be quality-regulated
- Cost less because demand for services would be lower than demand for cash payments.

(Campbell and Ikegami, 2003)

Compared with many other countries, support for both older and disabled people and for family carers in England is relatively extensive. Legislation has given carers rights to assessments of their own support needs, independent of assessments for disabled or older people; these must now consider carers' training, employment and leisure activities and aspirations. Carers also have independent entitlements to Carer Allowance, regardless of the services received by the person they are caring for, although the level of the benefit is widely regarded as unacceptably low. However these policies have developed separately from those for disabled and older adults. Consequently there has been little debate about how the care provided by families is treated in assessments of older and disabled people's needs for social care, especially in the new self-assessment and resource allocation processes being developed for personal budgets; in other countries family care is not taken into account in assessing the eligibility of an older or disabled person for social care. There has also been little consideration of how personal budgets and other current self-directed support measures might impact on carers and the levels of support they provide; this also requires urgent attention, given the rather mixed experience of other countries (Glendinning et al, 2008).

There are also strong arguments for a universal non-means-tested, tax free benefit for carers, similar to the Australian Carer Allowance, in recognition of the social, emotional and well-being costs of care. As with other universal benefits, this would also not act as a disincentive to carers seeking to remain in or return to paid work while caring.

Economic and political sustainability

A major driver behind the English 2009 Green Paper has been the need to develop arrangements that will be both economically sustainable in the face of marked future increases in the numbers of older people and politically sustainable in the context of rising public expectations about the quality and responsiveness of services. These two aspects of sustainability are closely related. Public willingness to pay, through increased taxation or insurance contributions, for high levels of publicly-funded social care is likely to be much greater if arrangements are perceived to be financially robust and durable with the consequent likelihood that tax or contribution-payers' expectations of receiving care in the future will be honoured.

Reforms in other countries have shown that a strong lead role for central government in bringing together resources from diverse sources to fund care, in setting eligibility criteria in the light of available resources, and in setting levels of social care provision for people with given levels of support needs is crucial for economic sustainability. The most efficient, and therefore sustainable, way of funding social care comes from maximum pooling of risks – whether through taxation or social insurance – as with the universalist approaches described above. The greater efficiency of universalist approaches is demonstrated by the comparisons in the English Green Paper of the contribution levels for an optional and a compulsory social insurance scheme – indicative contributions are lower for the compulsory scheme.

There are other ways of ensuring sustainability. One is to cap levels of social care funding for any individual. Thus in Germany, levels of social care funded through long-term care insurance have fixed ceilings; any changes in these and in contribution rates require federal legislation. Similarly the Austrian Care Allowance is paid at a standard level, at any given level of disability. The disadvantage of capped social care entitlements is that, as service costs rise, there is a growing shortfall to be met from personal resources (or from social assistance for the poorest). This became a major problem in Germany between 2000 and 2008 and led to increases in the private purchase of services and gaps in the amount of social care received by individuals.

A second approach to containing costs is to restrict the range of help funded through mainstream, universal schemes. In the Netherlands, 2007 legislation transferred responsibility for funding domestic (home) help services from the AWBZ social insurance scheme to municipalities. Domestic help had constituted 42 per cent of total AWBZ spending on domiciliary social and nursing care, so constituted a major source of expenditure. Municipalities are now responsible for devising and conducting assessments for domestic help, with widespread local variations; and for issuing competitive tenders to new cleaning companies.

Cost containment in Japan

Growing concerns about the rising costs of Japanese long-term care insurance have prompted restrictions on the services funded by the scheme.

- From 2005 most hotel costs in nursing homes were removed from coverage and became the responsibility of each resident. The new out-of-pocket charges are income-related, with the poorest paying no increase, and also vary according to levels of facilities (particularly single versus multi-bedded rooms)
- Between 2006 and 2008, social care services for people in the two lowest eligibility categories (those with lowest level needs) were restricted and partially replaced by preventive health promotion (diet, exercise) programmes delivered in day centres that also offer social activities. Domestic home help services were also withdrawn from these two lowest eligibility categories.

These (and other) measures have meant that only small increases in contributions will be needed up to 2012.

A third approach is simply to cut the prices that public sector purchasers pay for services. Thus the costs of the new cleaning contracts issued by Dutch municipalities are much lower than the domestic care services previously funded from AWBZ. Germany and Japan have also made cuts in the prices paid to service providers by their respective social insurance schemes. But these measures – and also the cash limited care allowances paid in Austria and Italy – place downward pressures on the social care workforce and increase the risks that social care is provided by a growing ‘grey’ labour force of unskilled and unregulated workers. Indeed, pressures on the paid care workforce have been identified as a major problem across Europe (EC, 2008) and the employment of recent non-EU migrant workers has increased more rapidly in the health and social care sectors than across the EU as a whole. While this is not a major issue in England at present, it could become so in the future.

In summary, countries that have universalist approaches to social care have generally maintained these. Rather than becoming more selective and restricting publicly-funded social care only to the poorest people, they have tended to cap levels of support or restrict the range of publicly-funded social care, with domestic help most likely to be excluded. These strategies enable universalist social care arrangements to be maintained, in which access depends solely on the level of disability or help needed rather than ability to pay. Only Australia has significantly restricted the coverage of state-funded social care to middle- and higher-income older people over the past decade, through an explicit liberal ‘user pays’ policy which has attracted widespread criticism.

Ultimately, however, increases in contributions may be the only option – but these may be politically easier to secure if the electorate is confident of long-term stability and the prospect of benefitting in the future if and when they need social care support. Thus in 2008 contributions to German long-term care insurance were increased for the first time in 15 years, from 1.7 per cent to 1.95 per cent of gross salary for people with children and from 1.95 per cent to 2.2 per cent of gross salary for childless people. However, these were implemented alongside increases in individual care benefits and additional funding for new community care centres to provide care management and advice; for voluntary sector respite care services and for staffing in nursing homes for people with dementia. It is likely that these increases in provision, along with the widespread popular stake in the insurance scheme, helped to mitigate opposition to increased contributions.

conclusions

While the challenges of developing sustainable social care for the future are undoubtedly real, the experiences of other countries indicate that they are far from insurmountable.

Of course many countries, such as the new eastern European and Baltic members of the EU, are struggling to develop even a basic network of non-institutional social care services, particularly in rural areas. But in western European, Scandinavian and other developed welfare states, social care provision appears surprisingly resilient in the face of the twin pressures of fiscal constraint and population ageing. From this brief survey of current international trends and reforms, three broad themes can be identified. First, there appears to be a widespread commitment to developing and/or maintaining universal access to social care. Previous fragmented, uncoordinated and locally variable arrangements are being replaced with national schemes in which conditions of eligibility for social care are the same across the country; sometimes these conditions are formalised as clear entitlements. The commitment to universality also covers younger as well as older disabled people – it is rare for reform measures to focus solely on older people. Major questions therefore arise about the equity of the English Green Paper's proposals to establish different arrangements for older and younger disabled people. Moreover, no reforms to universal schemes in other countries in response to financial or demand pressures involve excluding the well-off or targeting social care services only on the poorest. Rather, it is more likely for certain types of help, particularly hotel costs in institutional settings and domestic home help services, to be excluded from publicly-funded social care.

Secondly the offer of a cash allowance as an option or instead of social care services in kind is widespread, but can have several underlying aims. Sometimes cash allowances are intended, as in England, to empower social care service users and enable them to exercise greater choice and control over their support arrangements. However it appears that formal service providers do not always respond to these new consumer demands with a wider range of flexible, individualised services. Moreover, pressures on formal service providers are actually reduced if cash allowances are used to purchase support from family and friends or (in the case of some countries) to employ migrant 'grey' labour. Furthermore, while cash allowances may empower service users, the implications for informal carers may be less positive if the care they provide is regarded as a substitute for formal service provision.

A third – and perhaps the most important – theme is the role of central governments in ensuring universal, equitable and sustainable social care. In federal countries like Germany, Austria, Spain and Australia, regional governments have considerable local autonomy including responsibilities for raising taxes and regulating services. Nevertheless even in these countries social care policy, resources, eligibility criteria and quality regulation are determined at a national level. It is only through national governments that regional variations in resources, eligibility criteria and levels of service provision can be reformed and spatial equity ensured and this has been a major driver for reform in many countries. Central government responsibility for social care maximises the pooling of risks; enhances budgetary control mechanisms (including eligibility criteria and thresholds); safeguards spatial, diagnostic and inter-generational equity; ensures that regulation and quality control mechanisms apply across the country; and is consistent with principles of universality. Central government can also offer political legitimacy by championing the rights and social inclusion of people needing social care and their informal carers, and by defending public expenditure on services that might otherwise lose out to, say, the acute health sector. (Indeed, in Germany and Japan, reducing demands on the acute health sector from older people who had no other source of support was a major driver behind the creation of comprehensive long-term care schemes.) This is not to suggest fully centralised social care arrangements; on the contrary, local authorities can have vital roles to play in conducting assessments; helping social care users plan and access their preferred support arrangements; and working with service providers to ensure a wide range of good quality service options are available in response to local demand.

A shift in the traditional responsibilities of central and local governments for social care is clearly anticipated in the English social care Green Paper. The strong messages from earlier consultation events led to the inescapable conclusion that 'everyone who needs care can get it regardless of where they live' (HM Government, 2009: 122). National dimensions of a new National Care Service would include a standardised assessment process; a nationally applicable threshold of eligibility for state funding; and national uniformity on the proportion of an individual's care and support package that would be met from public funds. The Green Paper does not make an unequivocal commitment to a fully national system and proposes one option in which local authorities would still be responsible for deciding how much an individual should be given to spend on their care and support. However the Green Paper does recognise that a shift towards greater central government control would require changes in the respective financial responsibilities of central and local governments. If central government becomes responsible for deciding on the levels of resources allocated to individual service users, then it would be unfair to expect local authorities to contribute resources from local council tax – instead, central government would become responsible for raising all the resources for social care, from taxation and insurance mechanisms. Such a move would be entirely consistent with patterns of reform elsewhere in the world.

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