STATES OF JERSEY

LONG-TERM CARE FUNDING: CONSULTATION PAPER

Presented to the States on 15th January 2010
by the Minister for Social Security

STATES GREFFE

2010 Price code: E R.5

Social Security Department

Green Paper

The funding of long-term care in Jersey

15 January 2010

Purpose and type of consultation

The purpose of this Green Paper is to seek responses from the general public and other interested parties on how long-term care in Jersey should be funded in the future.

Deadline for submission of responses 31 March 2010

Summary

What is this Green Paper seeking to do?

The purpose of this Green Paper is to seek responses from the general public and other interested parties on how long-term care in Jersey should be funded in the future. The paper makes clear the full extent of the estimated cost of long-term care in the Island and who is presently funding it. Explanations are given as to why the overall cost of such care is likely to rise in the future and readers are asked for their views on how these costs should be paid for. In particular, people are asked to comment, via a questionnaire, on the balance between States funding – and whether this should be increased – and the level of payment required by an individual should they need care.

Throughout, a principal aim of the document is to stress that the amount and type of care the States can fund is directly linked to the contributions or taxes that are raised. The greater the coverage of any funding scheme, then the higher the contributions/taxes needed from the public to fund it.

Your submission Please note that consultation responses may be made public (sent to other interested parties on request, sent to the Scrutiny Office, quoted in a published report, reported in the media, published on www.gov.je, listed on a consultation summary etc.).

Please delete the following as appropriate:
I agree that my comments may be made public and attributed to me
I agree that my comments may be made public but not attributed (i.e. anonymous)
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As a Green Paper, the intention is not to make formal proposals. However, for the sake of stimulating discussion and encouraging views, four main options are set out:

- Maintain the current system
- Move to a fully means-tested system for all long-term care
- Provide all long-term care free of charge at the point of delivery
- Introduce a new long-term care benefit that meets some of the cost of care, with means-tested assistance for those unable to meet their share of the cost.

It is the intention that that the responses to this consultation will inform firm proposals that will be published as a White Paper in 2010.

What is the problem and why is it an issue now?

In common with many developed countries, Jersey's population is ageing. With people living longer, there is likely to be a doubling in the number of people needing care by 2026. At the same time, there will be fewer working age people paying taxes. So, at a time when the amount of money needed is rising, the pot of money – as presently constituted – to fund the necessary care is diminishing. The situation is exacerbated by the fact that the costs of care have traditionally risen faster than inflation.

Alongside this, there are other demands on the public purse in the Island, such as the need to fund the Social Security pension, meet rising healthcare and hospital costs, and fund major infrastructure projects.

Next steps

During the consultation period, a number of public events will be arranged so that people can comment on the range of proposals in the paper. Focus groups will also be organised to find out the views of interested parties. Responses will be collated and these will inform a White Paper to be published later in 2010.

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Further information

Copies of this Green Paper and the accompanying summary document and questionnaire are available from the Social Security Department and from Cyril Le Marquand House, the public library and parish halls.

Copies of all the documents can be viewed and downloaded at www.gov.je and the questionnaire can also be completed online.

Please send completed questionnaires and written comments to:

Long-Term Care Consultation
Social Security Department
PO Box 55
Philip Le Feuvre House
La Motte Street
St Helier
JE4 8PE

How to contact us:
Enquiries: Mark Richardson
Tel: 445505
Email: longtermcare@gov.je
Fax: 447446

This consultation paper has been sent to the following individuals/ organisations:

The Public Consultation Register
States Members
Health and Social Services
Housing
Planning and Environment
Treasury and Resources

Abbeyfield Jersey Society
ACET
Age Concern/Senior Citizens' Association
Alzheimers Society Jersey
AMOS Group of Christians Together
Arthritis Care
Autism Jersey
Cancer Bacup
Cancer Research UK
Catholic Church of Jersey
Citizens' Advice Bureau

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Communicare
The Dean of Jersey
Eastern Good Companions
Family Nursing and Home Care
Good Companions Club
Guardian Nursing Home
Institute of Directors
Jersey Association for Spina Bifida and Hydrocephalus
Jersey Association of Carers' Incorporated
Jersey Association of Retired Persons
Jersey Blind Society
Jersey Cancer Relief
Jersey Care Federation
Jersey Chamber of Commerce
Jersey Cheshire Home
Jersey Childcare Trust
Jersey Consumer Council
Jersey Dental Association
Jersey Employers' Network on Disability
Jersey Employment Trust
Jersey Epilepsy Association
Jersey Focus on Mental Health
Jersey Island Federation of Women's Institutes
Jersey Multiple Sclerosis Society
Jersey Parkinson's Disease Society
Jersey Relief for the Needy Trust
Jersey Society for the Disabled
Jersey Stroke Society
Jewish Congregation Education
L'Hermitage
Mencap
Methodist Church in Jersey
Motor Neurone Disease Association (Jersey)
Nursing agency owners
Personal care agencies
Pharmacists' Negotiating Committee
Primary Care Body
Roseneath Centre
SCOPE
Silkworth Lodge
Social Security Advisory Council
Standing Forum of Women's Organisations in Jersey
Tenant Participation Team
The Salvation Army
The Shelter Trust
Unite (TGWU)
Women's Refuge

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Long-term care in Jersey
How should we pay?

A public consultation on the funding of long-term care in Jersey

Green Paper

States of Jersey
Social Security Department

This is the main consultation Green Paper on the funding of long-term care published by the Minister for Social Security. If you would like a printed copy of this document or the accompanying summary document and questionnaire, please contact the department, or pick one up from Cyril Le Marquand House, the public library or from parish halls.

The consultation will run from January to March 2010. Please complete the questionnaire booklet and send it to Social Security no later than 31 March 2010.

This document and the summary are also available online at www.gov.je and the questionnaire can be completed and submitted online.

Please send completed questionnaires and written comments to:

Long-Term Care Consultation
Social Security Department
PO Box 55
Philip Le Feuvre House
La Motte Street
St Helier
JE4 8PE

How to contact us:

Enquiries: Mark Richardson
Tel: 445505
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Minister's foreword

The Strategic Plan published by the Council of Ministers in early 2009 identified the need to plan for the ageing population as a key priority. The Social Security Department is taking the lead in co-ordinating the actions that Jersey will be taking to ensure that the Island is well prepared for the challenges ahead.

Inevitably, there will be extra costs associated with an ageing population and one issue that concerns many local families is the cost of long-term care. The current system for supporting care costs is difficult to understand and has been the subject of some criticism. The number of people aged over 80 will double by 2026 and it is essential that we consider now how to put in place a system that strikes the right balance between the user and the taxpayer and is robust enough to deal with the increasing demands that we will need to put upon it.

The aim of this paper is to both inform and engage. Until families need to organise care for a relative, many people have little idea of the range or cost of care services available in Jersey. This paper provides a summary of the current provision in the Island together with an estimate of the total amount that is spent on care at present. The publication of this paper marks the start of the consultation process and a range of meetings will also be held to ensure that the views of Islanders are taken into account.

At this stage, I am not making any recommendations. Rather, the paper sets out four options to form the basis of these discussions. There are many demands on us as taxpayers at the moment and it is very likely that contributions and taxes will rise over the next few years for a variety of reasons. It is vital that we understand the range of costs associated with the different options and make an informed decision as to the role of government in the funding of long-term care in the future.

Please take the time to answer the questions in the booklet. During 2010 we will collate all the written responses and the feedback from the meetings, which will inform a policy document setting out specific proposals. One day, we, or someone close to us, may need long-term care and therefore we all have an interest – not least as taxpayers – in the standard of care, the cost of delivering it and how it is paid for.

Ian Gorst
Minister

Executive summary

Introduction (section 3)

This paper looks at the future funding of long-term care. A review is necessary because the population is ageing rapidly. It is likely that the number of people needing care will at least double in the next 20 years and continue to rise after that and it is important to agree now how to meet the cost of the care that they will need.

The adults who are the focus of this report – including an increasing number of younger adults with disabilities – all have at least a certain level of care needs. They need long-term help with the activities of daily living (washing, dressing, etc.) and their care needs are such that they would be eligible for a place in a care home. Not all of them live in care homes as some people choose to stay in their own home and receive help with care there.

Other adults have lower care needs and currently receive help in their own homes. The lower-level care given to these adults is not covered by this report.

The provision of community-based care services is likely to be enhanced over the next few years and any funding solution will include the possibility in the future of supporting these community services as an alternative to paying for care in a care home.

Current care provision and the cost of this care (section 4)

The cost of the care given to adults with high care needs is currently shared between Health and Social Services (HSSD) £16 million p.a., Social Security (SSD) £14 million p.a. and individuals £25 million p.a. (estimated). The amount that the individual pays depends on their age, their income, their savings, how they receive the care and the level of their care needs. The current system has built up over a long period and is complicated, with some people receiving most of their care free, others paying the full costs themselves and many a combination of the two. Help with care fees is only available from SSD if the individual cannot afford to pay themselves.

HSSD runs nursing care homes for people aged over 65 and group homes for younger adults with special needs. Other care homes are provided in Jersey by commercial organisations, parishes and charities. In the community, Family Nursing and Home Care (FNHC) and private firms provide nurses, personal care and domestic support services. Respite care allows unpaid carers to take a break from looking after their relatives. The States provides some respite care facilities with some provision also available in the independent sector.

The total cost of living in a care home can run from £500 per week to over £1,400 per week, depending on the home, the type of care that is needed and the standard of accommodation provided. The cost can be split into everyday housing and living costs (accommodation costs), which do not depend on care needs, and the cost of looking after someone (care costs), which varies depending on their care needs. In this report, everyday housing and living costs (accommodation costs) are taken to be £267 per week. Of the total annual estimated cost of care in the Island of £55 million, about £15 million is calculated to be in respect of accommodation costs.

How will care costs increase in the future? (section 5)

Latest estimates are that care costs will double in real terms (not including inflation) by 2026. As well as an increasing number of elderly people needing care, the standard of care provided is likely to rise. Fewer people will be looked after by their relatives than in the past and there will be an increasing requirement for support from a growing population of younger adults with disabilities.

Setting up a new system to fund long-term care will not have a major impact on the cost of care in the future – these costs will rise anyway.

The way forward (section 6)

Four possible options are suggested. Each creates a different balance between States funding and payments made by people at the time that they need care. The table summarises the cost of each option if it was in place today.

Current annual cost in £ million	States funding (£ million)	Private funding (£ million)
Keep the current system	30	25
Introduce a fully means-tested system	27	28
Provide all long-term care free at the point of delivery	55	0
Introduce a new long-term care benefit to meet some of the costs of care	45	10

Whichever option is chosen, the total cost of care is likely to double from £55 million per annum at the moment to at least £110 million a year by 2026 (at 2009 prices).

Option 1. Keep the current system
Both the States and individuals will pay more in the future to meet the costs of more people needing long-term care.

Option 2. Move to a fully means-tested system
One option to simplify the system would be for all long-term care services to be charged at their actual cost, with a means testing system providing support to people who could not afford the full fees. Because means testing is already used extensively in the current system, this would not have a major impact on the balance between States and private funding, but it would make it easier to understand how the system worked and improve the equity of the funding provided. It is difficult to make a firm estimate but States spending could be reduced by approximately £3 million a year as more people who could afford to, would pay towards the cost of services they currently receive free.

Option 3. Introduce free long-term care
Another way of simplifying the system would be to provide all long-term care free of charge. The States would need to raise an estimated extra £25 million a year to pay for this, even before the additional costs of an ageing population are taken into account.

Option 4. A combined approach guaranteeing some payment for all
The fourth option is to introduce a benefit that meets some of the costs of long-term care for all, but requires those who can afford it to make a payment towards some of

their own costs at the point when they require care. The benefit would be available regardless of income or assets. Guernsey has this type of scheme.

The total 'cost' of long-term care is often split into the costs of care and the cost of accommodation, on the basis that people need to pay for their everyday housing and living costs anyway if they were living in their own home and there is no reason for this to be subsidised just because someone needs care in a care home. Under Option 4, the States would pay for all nursing/personal care, but people would be expected to pay their own accommodation costs, with means-tested assistance available for those who could not meet all of this cost. The costs quoted in this paper are based on an accommodation cost of £267 per week, which is the figure used by the UK government. This figure will need to be calculated specifically for Jersey if this option is taken up.

There are many variations on Option 4. To reduce the cost to be met by the States, as well as paying their accommodation costs, people could pay, say, the first £100 of care cost per week or be responsible for paying a certain percentage of the care costs, say, 20%.

The Health, Social Security & Housing Scrutiny Panel recommended another variation on Option 4, in which a basic benefit is available to everybody, regardless of their income, but the benefit is paid at a higher rate to those with lower incomes. This would be in addition to the means-tested support that would help those on the lowest incomes to meet their costs.

Funding (section 7)

As well as increasing care costs, there are many other pressures on States spending. Contributions will have to rise to maintain the value of the Social Security pension and to meet the increasing health costs associated with an ageing population. The recession means that taxes may also need to increase to cover the cost of providing existing public services.

Whichever option is chosen for long-term care funding, the States will need to raise additional money to meet the increasing cost of long-term care. The money raised could be set aside in a separate fund to be used only for long-term care costs.

The States could obtain the funding by, for example:

- raising the level of income tax for individuals – increasing the standard rate of personal income tax by 1p would raise £7 million a year
- increasing the rate of GST – increasing GST by 1 percentage point would raise £14 million a year
- increasing social security contributions for employees aged under 65 – increasing the contribution rate by 1 percentage point would raise £14 million a year.

As most of the people needing long-term care are elderly, some countries have asked older people to contribute to long-term care funding. As the proportion of older people increases in the population over the next 20 years, they could make a valuable contribution to this funding. If older people do not contribute, the level of contributions made by working age people will need to rise even more quickly to keep up with the increasing cost.

Possible options for older people to contribute to the cost of care include:

- making a one-off contribution when they reach pension age to be eligible to receive help with long-term care costs, whatever they may be. If this option was adopted, a decision would be needed as to how to support people who could not afford to make the contribution. The UK government has suggested a figure of £20,000 but the cost in Jersey may well be higher.

- continuing to make Social Security contributions after the age of 65 – each 1% contribution from older people would raise an additional £1.7 million per annum.

At the moment, HSSD provides £16 million a year of long-term care funding. If a ring-fenced long-term care fund is set up, this HSSD funding could be transferred into it. This would reduce the amount of money needed to be raised from contributions. On the other hand, the hospital will need extra funding in the next few years and an alternative would be to allow HSSD to keep its existing funding and to use it for new hospital services, some of which will arise from the needs of an ageing population.

Means testing (section 8)

The current means-tested system determines the level of financial assistance provided by the Social Security Department to help with long-term care costs. It includes a capital allowance of £13,053 per single person or £21,636 for a couple. Savings and other assets below these levels are retained but any assets above this level must be used to pay towards care costs. Homeowners are provided with an interest-free loan to pay for care costs against the value of the property. Regular income is also used to pay towards care costs leaving an allowance of £30 a week for personal expenses.

It is likely that any new scheme will include at least an element of means-tested support.

The means testing of income under a new system could provide for a weekly allowance or a percentage of income could be exempted from the means-test. Alternatively, the Scrutiny Panel have proposed a system which provides a minimum long-term care benefit to everyone, with higher benefit rates available to those on lower incomes.

The treatment of assets in any means-tested system has already been the subject of public interest, with home owners arguing that the value of the main property should be excluded from any means-test. However, there are also reasons why it would be preferable to treat all types of assets, including property, in the same way.

The allowance for capital assets could be set at a level similar to the current levels, or a much higher level could be agreed, say £300,000. This would safeguard a substantial proportion of the value of an average property as well as protecting the savings of those who have been unable to purchase property during their working lives.

In some countries, people use private care insurance to meet their care costs. It is difficult to buy this kind of insurance at the moment but these products may develop in the future. If a system is chosen that is based mainly on means testing, private insurance could play a useful role in helping people to protect their assets. The States could automatically enrol people into an approved private care insurance scheme at an agreed age. They could then opt out of the scheme if they wanted, but

most people might choose to pay the contributions so that they would be covered for any care costs in the future.

Eligibility (section 9)

If new benefits are introduced, there will need to be eligibility conditions.

The assessment of care needs is an important factor in determining eligibility and a single method of assessment will be needed.

Residency is also an important factor. Access to any new benefit could be restricted to people who had lived in Jersey for a certain length of time, either at any time in the past or immediately before they needed care and/or who had contributed to a potential fund for at least a set number of years.

Introduction

The scope of this paper

This Green Paper provides information on all current funding streams supporting adults with high personal care needs in Jersey and the likely growth in these costs over the next 20 years. This paper does not address the detail of the funding package that will be required to meet future costs. This will be developed following the results of the current consultation and will be subject to further consultation and scrutiny before new laws are passed or new taxes or contributions introduced.

It is recognised that many charities provide invaluable support to local people with care needs. This paper does not attempt to quantify this support. However, charities and other voluntary organisations will continue to play a vital role in the provision of care and support in co-operation with States departments.

This paper only considers funding issues. Other States departments will be developing policies for the future delivery of long-term care. The Health & Social Services, Planning & Environment and Housing Departments will all be working in their own specialist areas to produce a complete picture over the next few years. In particular, the provision of community-based services is likely to be enhanced.

Although results from local surveys show that many people would prefer to receive care in the family home for as long as possible, there is currently a higher use of care homes for the elderly in Jersey in comparison with the UK where a broader range of community-based care services is available.

An expansion of community services (home care, support services to undertake minor repairs, community alarms, meals on wheels, etc.) and the availability of appropriate housing (warden-supported flats, etc.) would allow local older people to continue to live comfortably and safely in an environment they are used to, perhaps supported to an extent by their family, and therefore delay their entry into a care home.

The assumption is made in this report that any funding solution will ultimately include the possibility of supporting these community services as an alternative to funding a placement in a care home. However, it is possible that the changes to funding will be in place before a fully-developed community-based care system is available. Any new laws that are needed to cover the funding of long-term care will include the option to be extended to cover community services as soon as these can be provided and regulated in an appropriate manner.

This paper only considers the cost of care for adults whose care needs are such that it would be appropriate for them to be provided with care in a care home. It does not extend to those who have more limited care needs. However, as community support is built up over the next few years, the question of whether the funding system should be extended to people with these more limited care needs can be considered. Funding for children's services is not covered in this paper.

Summary of recent research about long-term care in Jersey

In 2003, the Health and Social Services Department undertook a variety of projects under the heading of ISAS (Island-wide Strategy for an Ageing Society). This included a survey ("the ISAS barometer") that identified, among other things, the most favoured option for long-term care funding was a compulsory insurance scheme run by the States (42%). The next most popular option was increased taxes (15%). Over half of all respondents reported that if their care needs increased, they would rather make modifications to enable them to remain in their current home than have to move into sheltered accommodation or a care home.

The Jersey Joint Secretariat for People with Special Needs and their Families has published a Community Living Strategic Plan covering the period 2006-2011. This reports the need for the continuing development of group homes for people with special needs as well as increased community support.

At the end of 2008, the Health, Social Security & Housing Scrutiny Panel published its report *Long-term Care of the Elderly (SR12/2008)*. The report stresses the importance of better information being made available to the public on the current system so that people understand the need for change and the increasing cost of care. The Panel favoured some form of partnership funding scheme including compulsory insurance and also recommended that funding should be based around the client and their individual needs.

The Jersey Annual Social Survey for 2008 included questions exploring similar issues to the ISAS survey from 2003. This group of respondents strongly supported (72%) the desire by those with increasing care needs to remain in their own home. Many people were uncertain as to how care costs should be funded in the future but, of those expressing an opinion, over 80% said that funding should come from the States through insurance or taxes. Nearly three-fifths thought that a funding scheme should be compulsory.

In 2009, the Carers' Strategy was published by Health and Social Services, in conjunction with the Jersey Association of Carers Incorporated. The strategy identified the importance of informal carers and set out a framework within which carers can be supported in future.

Current care provision

This section describes the different types of care provision that are currently available in Jersey.

This Green Paper refers to long-term care and long-term care costs using the following terms:

Accommodation costs - the everyday housing and living costs associated with staying in a care home.

Nursing care - care that involves the knowledge and skills of a qualified nurse. People needing nursing care have the highest care needs and also require personal care. Nursing care for people with high care needs is usually provided in a nursing home, but it may also be provided at home by a district nurse or a private nursing agency. Some reports refer to this level of care when provided in a care home as "continuing care". The total cost of nursing care includes the cost of accommodation, personal care and nursing care.

Personal care - care that assists with the normal activities of daily life, for example, personal toilet, eating and drinking. This is care that can be provided by a competent relative or by a healthcare assistant. Personal care may be provided in a residential home but people with personal care needs may also be cared for at home (community care) by an informal carer and/or care assistants provided by Family Nursing and Homecare or by private agencies. Many people receive their care through a combination of these services.

Residential care - personal care provided in a residential care home. The total cost of residential care includes the accommodation cost and the personal care costs.

Care homes for those over 65

Nursing care

Health and Social Services (HSSD) provides nursing care primarily for over 65-year olds in three purpose-built establishments. The Limes Nursing Home and Sandybrook Nursing Home offer 36 and 28 beds respectively. Accommodation for 62 residents with mental health nursing care needs is also available within the St Saviour's Hospital complex.

There are currently 78 service-level agreement nursing beds available in independent[1] sector nursing homes. These are beds that are purchased from other providers by HSSD, either on fixed-term contracts or in respect of a particular resident. Admission to these beds is by referral to the HSSD Older People's Service, either from a hospital doctor or a family GP. The HSSD team assesses these referrals and organises placements as beds become available. People waiting to be placed may be at home, in hospital or they may be in another care home, but their care needs have increased to such an extent that the current placement is no longer appropriate.

Most of the cost of the nursing care and personal care provided is covered by HSSD funding, but residents are charged a means-tested element under the terms of the

[1] Independent sector comprises charitable and for-profit organisations

Hospital Charges (Long-Stay Patients) (Jersey) Law 1999. The long-stay charge set for 2009 is £62.60 per day (£438.20 per week). People who cannot afford the long-stay charge can apply to Income Support for assistance with this cost. If the individual (or their partner) owns their main residence, then Income Support is provided as an interest-free loan to be repaid following the death of the individual (and their partner).

The Parish of St Helier provides five nursing beds at the St Ewolds care home. These are only available to existing St Ewolds residents whose care needs have increased. Nursing care is also available privately through independent sector care homes. At present there are 11 nursing homes registered in Jersey, with a total of 215 beds. As approximately 78 of these beds are contracted to HSSD, there are approximately 137 nursing care beds available for private clients. Private nursing care beds cost between £700 and £1,400 a week. People can place themselves independently in a nursing care home if they can afford the fees and the home manager is willing to accept them.

Residential care

Residential homes are not required by law to employ registered nurses. Care that is provided in a residential care home is broadly equivalent to what might be provided by a competent and caring relative.

The States does not own any residential care homes for over 65s. Two parishes and a number of charities and commercial organisations currently provide 698 places in 24 homes for people with personal care needs. Private residential fee rates currently range from £500 to £1,000 per week. People can place themselves independently in a residential care home if they can afford the fees and the home manager is willing to accept them.

People who require assistance with residential care fees can apply to Income Support. There is no waiting list for residential care placements under Income Support. Instead, a clinical placement tool is used to confirm that the personal care needs of the individual are sufficient to require residential care. Funding is made available once an appropriate care home agrees to accept the individual.

People who are assisted by Income Support are assessed as to their care needs and funding is available at two standard rates, depending on the amount of personal care that they need – for 2009 the rates are £580 and £750 a week. This fee covers the personal care costs **and** the accommodation costs and the full amount is subject to means testing. If the individual (or their partner) owns their main residence then Income Support is provided as an interest-free loan, to be repaid following the death of the individual (and their partner).

Care homes for under 65s

Jersey Cheshire Home

Leonard Cheshire Disability operates in all parts of the UK providing care and support services for physically disabled people. The local Cheshire Home, Eric Young House, provides accommodation for 25 individuals mainly aged under 65 with physical disabilities. There are 15 nursing beds and ten residential beds. The fees range from £750 to £1,250 a week. Almost all the residents receive financial assistance with their fees through means-tested Income Support.

Les Amis

Les Amis is the operational arm of Jersey Mencap, a learning disability charity. It operates 16 group homes, six flats and two bedsits, accommodating a total of 78 residents with learning disabilities. Most of the Les Amis homes are registered as residential placements, with individuals referred through the HSSD Special Needs Service.

Each group home is supported by a number of support workers and caters for up to five residents, dependent on care need, with three or four being ideal. The ages of the residents range from 18 to 75. Residents generally move into Les Amis from the family home at the age of 18.

The great majority of Les Amis residents have limited income and receive financial assistance with fees through means-tested Income Support

Health and Social Services group homes

HSSD operates 11 small group or community homes for people with learning disabilities and special needs. Four of these homes (which are a mix of houses, bungalows and apartments) are rented by residents as tenants in their own right. The remaining properties are owned by HSSD. Overall, there is capacity for 46 people. Most are aged under 65, but a number are over this age.

No fees are raised in respect of care or accommodation provided in these homes as the individuals are aged under 65 and deemed to be "in hospital". The full cost is met by HSSD.

Residential care for adults with mental health problems

Jersey Focus on Mental Health is a local charity, providing a range of residential care services to adults with mental health problems. The organisation provides long term and respite accommodation for eight adult residents (predominantly under 65) at Camelot. Longfields Villa provides accommodation and personal care for adults over the age of 50 with mental health problems.

Care provided in the community (all age groups)

The majority of people receiving informal care in the community have limited personal care needs and do not meet the criteria to be eligible for a place in a residential care home. However, there is a significant minority who would qualify for a residential care placement if they chose to take it up. In many cases, an individual moves into a care home only after their informal care arrangements have broken down (for example, following the death or illness of a partner, etc.).

Results from the 2009 Jersey Annual Social Survey suggest that just under one in ten adults provide some level of unpaid care to a relative, friend or neighbour[2]. This ranges from one hour per week to over ten hours per day. As well as helping with personal care, carers also assist with shopping, housework and dealing with money and appointments. Over half of those receiving help are aged 75 and above.

Full-time adult carers under the age of 65 may be entitled to claim Invalid Care Allowance (ICA), although there are eligibility restrictions on earnings and household

[2] 2009 Jersey Annual Social Survey

income. Just under 200 carers in Jersey currently receive ICA[3]. Full-time carers of any age in low-income households receive a carer's component as part of their Income Support benefit. There are a small number of children who act as carers for their parents.

Means-tested financial support through Income Support (impairment component) is available for people with high personal care needs living in the community. This is provided as a weekly benefit which can be used to help pay for FNHC or private agency costs.

Family Nursing and Home Care (Jersey) Incorporated (FNHC)

Care in the community is also provided by Family Nursing and Home Care – a local charity. FNHC receives just under three-quarters of its annual budget from HSSD under a service level agreement. Part of this funding is used to provide free district nursing and heavily subsidised personal care services as well as domestic support services.

Just over 100 FNHC home care clients have care needs sufficient to warrant a residential placement, although they remain living in the community. They pay an annual subscription (£45 / £65 pa) plus subsidised fees in respect of the care that they receive. People receiving between three and eight hours' care a week make a payment of £25.30 per week, and those who receive 8 to 21 hours per week pay £30.90 per week

District nurses, employed through FNHC, provide free nursing care to people in the community and, where appropriate, to people in residential care homes.

Other community support

Health and Social Services directly provides individual care packages to approximately 40 people aged under 65 living in the community who would meet the criteria for a residential care placement.

Private agencies also provide support at home. The current charge for domestic support services is circa £12.00/hr and £16.50/hr for assistance with personal care. Nursing agencies provide qualified nursing care from approximately £25 per hour.

Respite care

Respite beds accommodate people who are normally cared for by family carers at home. Respite gives the carer a break and can be provided on a regular basis (one night a week, for example) or in an emergency (for example, if the carer becomes ill). HSSD maintains four nursing beds and two residential beds providing respite care for the over 65s. People requiring respite services are assessed by HSSD. The respite is provided at no charge, but there is a waiting list of people for this service.

There is no dedicated respite provision for the under 65s with physical disabilities, but HSSD does provide limited assistance on a case-by-case basis. Not all respite care is (or needs to be) bed-based. It is also provided through various types of day care and the purchase of support packages for people living in their own homes.

[3] 193 active claims 31/8/09

Les Amis maintains seven respite beds for adults with learning disabilities, two of which are for those who also have a physical disability. These respite facilities are provided free of charge and are funded by Health and Social Services.

Following an amendment in the 2010 Business Plan, funding will be provided from 2010 for HSSD to provide an additional four respite beds for adults with special needs.

Respite provision is also available in the independent sector with fees ranging from £500 to £1,200 per week, depending on the needs of the client and the care home selected.

Summary of current funding arrangements

The costs provided in this section are based on a large number of assumptions and should be taken as providing an indication of the costs involved, rather than a detailed financial analysis.

Health and Social Services funding

Long-term care services funded by HSSD are not subject to means testing and are available to anyone who is provided with the service. These services include:

- nursing care
- group homes
- block grant to Les Amis
- block grant to Cheshire Homes
- block grant to FNHC
- respite care
- community placements

Means-tested support from Social Security (Income Support)

Income Support, administered by the Social Security Department (SSD), provides means-tested benefits to support long-term care needs in the following areas:

- long-stay charges for people placed in nursing beds by HSSD
- residential care charges (incorporating both personal care and accommodation costs) for people placed appropriately in residential care (including Les Amis and Cheshire Homes)
- people with high care needs living in low-income households.

Contribution from private individuals

Within the means testing system of Income Support, people make payments according to their financial circumstances. Most people with limited incomes will pay their full pension towards their care fees. They receive a personal allowance from Social Security of £30 per week. People whose level of savings or income means they are ineligible for Income Support pay the full cost of residential care or the long-stay charge from their own resources. People who choose to place themselves in nursing care pay the full fees themselves.

People receiving care in the community pay relatively small user charges in respect of FNHC services, but pay the full cost of private assistance with care needs.

The current total annual cost of long-term care, including accommodation costs, can be estimated at £55 million, as shown in Table 1.

Care type	HSSD provision of free or subsidised care (including some accommodation costs) (£ million)	SSD means-tested (Income Support) assistance with care and accommodation costs (£ million)	Client payments towards means-tested/ subsidised provision (£ million)	Private clients meeting their full care and accommodation costs (£ million)	Total (£ million)
Nursing care home 65+	8.1	1.6	3.0	8.2	20.9
Residential care home 65+	-	7.2	1.4	11.3	19.9
Under 65 care homes	5.3	4.2	0.3	0.2	10.0
Community Care - all ages	2.7	0.5	0.7	0.5	4.4
Total	16.1	13.5	5.4	20.2	55.2

Table 1: Analysis of current annual funding of long-term care costs

Table 1 only provides estimates of current long-term care costs. A number of assumptions have been made to produce these figures and they should not be taken as an accurate record of actual costs.

The figures are intended to provide context to the general discussion on future requirements for long-term care funding. A more detailed analysis will take place before any firm proposals are made.

Accommodation costs

Many countries that have a system of long-term care benefits differentiate between the cost of care and the cost of accommodation (everyday housing and living costs) in a care home. Under the current funding arrangements in Jersey, costs are not broken down in this way. To provide some indication of the split between the cost of care and the cost of accommodation, the accommodation figure calculated for the UK government (£266.70 per week[4]) is used in this paper. If it is decided to differentiate between the cost of care and the cost of accommodation in a future long-term care benefit system, then detailed calculations on local costs will be needed to establish the correct rate for Jersey.

Using the figure of £266.70 per week for accommodation charges, the total annual cost for people receiving care in a care home can be split into £40million for care costs and £15million for accommodation.

[4] *Analysing the costs and benefits of social care funding arrangements in England: technical report* by Julian Forder and Jose-Luis Fernandez (PSSRU Discussion Paper 2644, July 2009) p.20

Table 2 summarises the number of long-term care places available in Jersey care homes (as at August 2009).

Care type	Number of registered and HSSD beds
Nursing care home 65+	356
Residential care home 65+	699
Under 65s care homes	167
Total	1,222

Table 2: Capacity of Jersey care homes – August 2009

How will care costs increase in the future?

How many people could need care in the future?

Jersey's population is ageing and, as can be seen from the two tables below, the growth in the number of older people over the next 30 years is predicted to be faster in Jersey than in England.

Resident population (Jersey)[5]	2006	2016	2026	2036
0-15 years old	15,717	14,545	13,902	14,264
Adults aged 16-64	60,079	59,112	57,747	54,101
All adults aged over 65	13,597	18,036	23,373	28,563
Adults aged over 80	3,567	4,754	7,128	10,024

Table 3: Estimated growth in Jersey population 2006 - 2036

Resident population (England)[6]	2006	2016	2026	2036
0-15 years old	9,674,000	10,261,000	10,973,000	10,994,000
Adults aged 16-64	33,003,000	34,577,000	35,882,000	36,821,000
All adults aged over 65	8,087,000	9,886,000	11,828,000	14,216,000
Adults aged over 80	2,277,000	2,763,000	3,759,000	4,959,000

Table 4: Estimated growth in English population 2006 - 2036

In 2026, the number of people aged over 80 in England is forecast to have increased by 65% from the 2006 level. At that time, the number of people aged over 80 in Jersey is forecast to have doubled.

Ageing affects people in different ways at different times. Older people are a diverse group and old age does not automatically equate with accompanying illness and dependency. Some people in their 80s and 90s live independently in the community, while others in their 60s or 70s require help. There is no single point at which a person becomes old, frail and dependent; however, approximately one in four 65-year olds can expect to enter residential care later in their lives[7].

[5] Stats Unit Population model, assuming net immigration of 150 households per annum

[6] http://www.statistics.gov.uk/downloads/theme_population/pp2no26.pdf

[7] *Shaping the future of care together*, July 2009 [UK Green Paper], p.88

The need for care is not just from older people. There are increasing requirements for support from a growing population of younger adults with disabilities. For example, a few decades ago, children born with Down's syndrome in the UK would expect to live into their mid 20s, now they can live into their 50s[8]. The local Community Living Strategy for adults with special needs (learning disabilities and autistic spectrum disorders) identifies 34 additional individuals who are likely to need care services over the five-year period between 2006 and 2011.

Traditionally, many families have provided informal care to their relatives. Grown-up children often lived close to their parents and extended family networks were common. Nowadays, smaller family sizes and a much more mobile workforce mean that many people do not live close to relatives and the opportunities for informal care are reduced. If this trend continues, there will be a greater need for more formal, paid care, which will add to the future cost of care.

How long will people need care for?

Current UK statistics suggest that an average (mean) stay in a care home is about two years[9]. This figure is affected by a relatively small number of people who need care for a very long time. The majority of people (over 70%) do not remain in residential care for more than a year – the median length of stay.[10]

Improvements in medical treatments and increasing life expectancy make it difficult to predict how long people will need care for in the future. It can be argued that this length of time will either:

- **decrease** in the future because medical conditions will be controlled better and people will maintain good health for longer; or

- **increase** because people are living longer, but will still be subject to the diseases of old age so they will need care for a longer period.

The assumption made by the UK government is that the length of time that an individual will need care will stay about the same, on the basis that the two effects will cancel themselves out. Given the uncertainty in this area, this is not an unreasonable assumption to make at present.

How will the cost of care change?

The cost of care rises as people's expectations rise. For example, it is no longer acceptable to ask people to share a room, and facilities built today have private rooms with en-suite facilities as the norm. The UK government has assumed that care costs will rise by 2% per annum on average over and above inflation[11]. It is likely that Jersey costs will be subject to similar, above inflation, pressures from time to time in the future.

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[8] UK Green Paper, p.38
[9] UK Green Paper, p.98
[10] Forder and Fernandez (technical report) p.24
[11] Forder and Fernandez (technical report) p.27

How will people receive care in the future?

There is a high use of care home beds in Jersey at present. The recent Scrutiny report noted that: *"In 2007 there were around 850 people in local care homes (residential and nursing), which equated to approximately 140 people per 1000 population over the age of 75. This was considerably higher than the equivalent figure for the UK, of 85 residents per 1000 over 75."*[12]

It is hoped that, over the next few years, more services will become available to allow people to receive care in their own homes. This will help to control the increase in costs as a care package would only be funded in the community if the cost was no more than the cost of the equivalent care in a care home.

Summary of future care costs

An advisor to the UK government summarised the pressures on care costs as follows:

"Across Europe, data suggest that an ageing of the population, coupled with changes in the availability of informal family support, increasing costs of care and raised expectations on the quality, intensity and flexibility of services may raise major challenges for policy makers contending with maintaining or extending coverage and support for long-term care systems. Long-term care expenditures are projected to increase from just over 1% of GDP in OECD countries to between 2% and 4% of GDP by 2050..."[13]

It is impossible to predict precisely the total cost of care in the future. A computer model developed on behalf of the UK government indicates that care costs will double between 2010 and 2026[14]. Due to the greater proportion of older people in the Jersey population, local care costs are likely to increase by at least this much, if not more.

At today's prices, this suggests that the current total cost of £55 million would rise to at least £110 million by 2026.

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[12] *Long-term care of the elderly* – Health, Social Security & Housing Scrutiny Panel, December 2008 [Scrutiny Report], p.35

[13] *How can European states design efficient, equitable and sustainable funding systems for long-term care for older people? by Jose-Luis Fernandez, Julien Forder et al (Policy Brief 11, 2009, World Health Organisation Europe)*

[14] Forder and Fernandez (technical report), p.36

The way forward

The remainder of this Green Paper looks at how long-term care in Jersey could be funded in the future.

A number of terms are used in this paper when describing the different types of funding:

Contribution – the amount paid by an individual towards government funding of long-term care benefits (in advance of needing care)

Payment – the amount an individual pays towards their own long-term care costs at the time they need the care, including possibly both care costs and accommodation costs. In some papers this is referred to as a "co-payment".

Income Support – a means-tested benefit available to help claimants meet the cost of their own care at the time that they need care. The amount of Income Support provided depends on the income and assets (savings, investments and property ownership) of the claimant.

Long-term care benefit – a benefit that could be introduced to meet some or all of the costs of long-term care. The value of the benefit would not depend on the income or assets of the claimant. The benefit could be provided in various ways, for example, the provision of a bed in a care home, a cash payment, or a voucher to exchange for a care service.

Long-Term Care Fund – a dedicated (ring-fenced) fund that could be set up specifically and solely to meet some or all of the costs of long-term care.

What are the pressures for change in Jersey?

Over the last few years, the suggestion has regularly been made that Jersey should introduce a long-term care benefit similar to that available in Guernsey. The main rationale behind the suggestion is to protect the rights of property owners to pass their properties on to their children. However, introducing a scheme to achieve this would place a higher proportion of long-term care costs with the government and increase the amount to be raised through contributions or tax.

More recently, with the growing understanding of the impact of the ageing population on the local economy, a review of long-term care funding is seen as necessary to ensure that the growth in government funding is controlled in the future and does not rise too quickly as the number of people needing care increases at the same time as the number of working age people decreases.

Another pressure is the complexity of the current system with different funding streams available for different types of care and provided by different States' departments. At the moment, some aspects of nursing care and community-based care in Jersey are either provided free or are heavily subsidised. Other types of personal and residential care are not available free. These funding mechanisms have been developed over many years to address specific needs at the time. Unfortunately, the net result now provides inconsistent support. Some people with high care needs pay for most of the cost of their own care; others with similar needs pay much less.

These pressures need to be considered when deciding the action that should be taken in the next few years.

How have other countries addressed the problem of long-term care funding?

In "*Long-term care for older people in Jersey*", Professor Forder[15] wrote: *'Many countries are reconsidering how to pay for care. They are questioning the balance of funding between state and individual, between means-tested and universal funding; and between funding against risk (in advance) and funding at the point of need.'*

Jersey is not alone in facing the challenge of an ageing population combined with a shrinking workforce and pressure on finances. It is useful to see how these challenges are being met elsewhere. Guernsey introduced a long-term care benefit in 2003 (as described below). The UK has recently published a Green Paper[16] on funding long-term care in England, and Scotland has already introduced free personal care. Further details can be found in the appendices to this Green Paper.

The Guernsey long-term care insurance scheme

Under the Guernsey scheme, in return for a 1.4 per cent[17] social security contribution paid by everyone over 18, including retired people, a benefit is provided towards the cost of fees for a private care home (£360 per week residential care, £672 per week nursing care). The individual is responsible for making a standard payment (£162.40 per week). Those that cannot afford the standard payment receive help through means-tested Supplementary Benefit. One of the principles of the Guernsey scheme is that a person going into care should no longer be required to sell their home before they can receive help with care home fees. Ownership of a main residence or having savings does not stop someone from claiming the long-term care benefit.

The benefit covers about two-thirds of care beds in Guernsey. Remaining beds are owned by the States of Guernsey and are funded separately. The Guernsey scheme does not currently cover the cost of home care, but it does cover adults of any age, not just older people.

This scheme followed the introduction in Guernsey of a Specialist Health Insurance Scheme (to cover the costs of some hospital consultants and associated hospital services) and involves the collection of contributions from people over 65 as well as the working age population.

It should be noted that the Guernsey scheme has no mechanism for controlling the cost of fees charged by private providers; it does not provide any assistance with care provided in the community; and it does not cover care homes owned by the States – Guernsey provides both residential and nursing care places through States-owned facilities. The Guernsey scheme is currently under review. (Further details of the Guernsey Long-term Care Insurance Scheme can be found at Appendix 3.)

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[15] *Long-term care for older people in Jersey* – Prepared for the Health, Social Security and Housing Panel by Julien Forder, November 2008, p.5

[16] *Shaping the future of care together* [UK Green Paper], July 2009

[17] Details of Guernsey scheme refer to rates for 2009

How should the cost of care be shared between the government (the States) and the individual in the future?

As part of the review of the funding of care costs, it is important to ensure that any changes work towards creating a system that is

- simple to understand
- easy to access, and
- perceived to be fair.

It is also important that any changes that are made to care funding encourage individuals and healthcare professionals to make care choices based on the best outcome for the individual, rather than being governed by consideration of the funding stream associated with the type of care.

For example, under the current system, HSSD provides some services either free or at a substantial subsidy. If a new system is introduced, the services provided by HSSD will be charged at market rates with the cost being met through the new funding streams.

The funding of care in the community is patchy at present and not everyone is able to choose between staying at home with a care package or moving into a care home. It is important that funding for community care, where people can be looked after in their own home for as long as possible, is made available in a simple package to provide a realistic alternative to a care home placement. Any laws that are required to set up a new benefit will include this option.

Developing appropriate community services will help to control the cost of care in future, as well as providing individuals with more choice. The suppliers of services provided to people in their own homes will need to be regulated and approved and this is likely to require additional legislation.

Four options for sharing the cost of care are described below:

Option 1. Maintain the current system

Under the current system, the cost of care is shared between the government and individuals (who make payments when they need care). States expenditure is approximately £30 million, with individuals paying approximately £25 million per annum at the point of delivery. Given the many other pressures on States finances at present, the need to review long-term care funding may be seen as having a lower priority than other projects at this time. In particular, any proposal to increase taxes or contributions to fund a new long-term care benefit may be unpopular at a time when there are significant other pressures to increase contributions and taxes.

If, in the light of these competing pressures, the current system remains largely unchanged, incremental improvements could still be made. Work has already been undertaken to streamline decision-making between HSSD and SSD and to improve the level of information available to the general public. Looking forward, steps could be taken to reduce in stages the difference between funding for nursing care and personal care needs.

Even if it is decided to maintain the current system, there will still be a need to raise additional States funding to meet future costs.

One advantage of replacing the current system is that any new system could assist with both personal care costs and nursing care costs in the same way. This would make it easier for people to understand how they are supported as their care needs increase. The Guernsey long-term care scheme covers both personal (residential) and nursing care costs.

Option 2. Move to a fully means-tested system

One possible replacement system would involve an extension of the current means testing of care costs to put more onus on the individual to pay for their own care. All care and accommodation could be provided at market cost, with Income Support providing financial assistance only to those who could not afford to meet their own payments.

Schemes based fully on means testing are normally funded through general taxation. In broad terms, benefits that are 100% means-tested require the smallest contribution from the public purse. The cost of care is not shared evenly throughout the population. There is redistribution from wealthier people to less wealthy people as those with higher incomes contribute to taxation and those with lower incomes claim assistance with their care costs. Higher income people and those with assets are required to meet much of their own care costs. In taxation terms, this is a progressive option with redistribution from richer to poorer people. There is already a considerable amount of means testing in the current system, but it is estimated that extending means testing consistently to all areas of long- term care would reduce current public expenditure by about £3 million a year to £27 million annually.

Option 3. Introduce free long-term care at the point of delivery

At the other end of the spectrum, all care and accommodation costs could be provided completely free at the point of delivery – in other words, the costs would be funded entirely by the States through the taxpayer, like most in-patient hospital treatment now. This would be the most expensive option in terms of the public funding that would be required. This funding could come from general taxation or from a dedicated fund. There would be no means testing. Under this scenario, no one would be required to pay more due to their high care needs (regardless of their income or assets). Currently, individuals contribute approximately £25 million a year to their own care costs and the States would need to replace this expenditure by raising this sum through contributions or taxes. This would be in addition to the £30 million or so that the States funds now. It would mean the States funding all care and accommodation costs to the tune of £55 million a year.

Compared to the existing system, this option would reduce, on average, the amount paid by wealthier people and increase, on average, the amount paid by middle and lower-income people. The wealthy person with high care needs would receive their care free (even though they had the means to pay for it and currently would be expected to make some payment towards their care and accommodation costs). Those on middle and lower incomes would receive the same assistance as now when they needed care, but they would be paying extra through their taxes or contributions to help fund the overall scheme. The poorest section of the population could be unaffected if contributions were collected based on income via social security contributions or income tax. This option could be made more progressive in tax terms if the method used to raise contributions was, itself, progressive, so that richer people paid proportionately more in their contributions than less well-off people.

The provision of free care for all is viewed by many governments as an unsustainable demand on the public purse as care costs increase in the future.

The diagram illustrates Options 2 and 3. The heavy vertical lines represent the cost to government of funding long-term care. Using this diagram, the USA (which only provides means-tested assistance to its poorest citizens) would be positioned towards the left-hand side, whereas Denmark (which provides a generous range of tax-funded services to most people) would be towards the right-hand side.

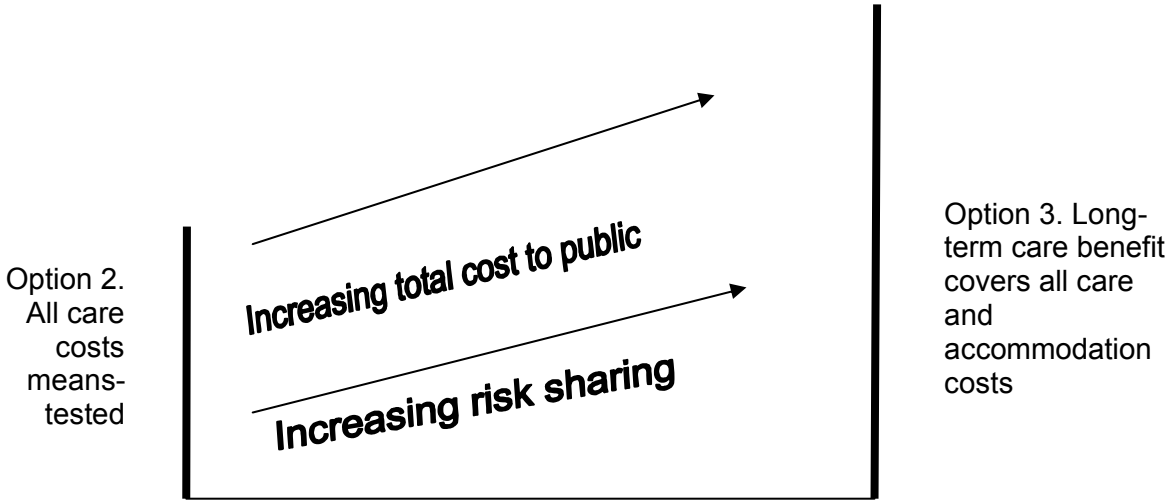

Diagram 1: **Comparison of options 2 and 3**

Option 4. A combined approach, including a long-term care benefit and some degree of means testing

Some governments have adopted an approach that combines a level of support for all – a long-term care benefit, paid for from a separate fund and paid regardless of income or assets, together with a means-tested element to cover some aspects of care costs. Guernsey, for example, has adopted an approach of this type.

The total cost of care in a care home can be split into the cost of the nursing/personal care and the cost of the accommodation itself. Many countries that have recently reviewed their care systems exclude accommodation costs from their long-term care benefit, as these are costs that the individual would have incurred anyway in their day to day living. Under the current Jersey system, most people aged 65 and above make a contribution towards their accommodation costs if they can afford it, although a small number of people aged under 65 in HSSD-owned homes do not pay anything.

It is difficult to set a figure for accommodation costs in Jersey as fees are not currently analysed in this way. To give an indication of the possible split between costs, the figure identified by the UK government for accommodation (£267 per week) is used in this report. If this option is pursued, additional work will be needed to calculate an appropriate figure for Jersey. Detailed negotiations will take place with care providers and regulators before any firm proposals are put forward.

Based on the claimant paying an accommodation charge of £267 per week, the cost to the States of providing a benefit to cover all the care (nursing and personal) costs but **not** accommodation costs would be £45 million a year, £15 million higher than the States current budget.

As with Option 3, this approach would tend to reduce the amount paid by those with higher incomes and increase the cost to those with lower incomes.

There are many variations on Option 4, depending on the proportion of total costs that are met by the long-term care benefit. If the funds available to meet the costs of the benefit are not sufficient to cover 100% of care costs, then the long-term care benefit could be designed to meet only a certain proportion of care costs. For example, the benefit could cover 80% of assessed care costs, at a total annual current cost of £37 million (a reduction of £8 million p.a.). The individual would pay the remaining 20% of care costs, in addition to paying the accommodation costs. This would mean that those with the highest care needs would pay more, but the cost to them would only be a fraction of the total cost.

Alternatively, everyone could make a standard payment towards their care costs and the benefit could meet the additional cost (up to an agreed maximum fee level). For example, if a fixed payment of £100 per week was required towards care fees, the total cost to the dedicated fund would be reduced by £7 million to £38 million a year (i.e. long-term care benefit covers all care costs over and above the first £100 per week; the individual meets the fixed £100 payment towards the care costs, plus any accommodation costs).

In both cases, the cost to Income Support would increase as the level of the long-term care benefit decreased.

The French "partnership social insurance" model recommended by the Scrutiny Panel in its 2008 report[18], provides another variation. It includes elements of means testing within a long-term care benefit provided through a dedicated fund, so that as well as providing an agreed minimum level of support to everyone, a higher level of support is provided to people with lower incomes using staggered means-tests.

If a separate fund is set up and income or assets levels are considered in determining the level of benefit that is provided, then people with **substantial** incomes and/or assets could be completely excluded from receiving any benefit. This would deny those individuals the risk-sharing benefits of a dedicated fund and their contributions would effectively be a tax.

Options 3 and 4 will provide additional benefits, payable to people regardless of their level of income or assets. It is likely that under the current system some people are not receiving all the care that they need because they have chosen not to pay for it themselves, nor to seek means-tested assistance. The costs set out below do **not** include any allowance for additional demand from people who are currently not receiving all the care that they need. This is likely to lead to Options 3 and 4 costing more than the estimates provided.

[18] Scrutiny Report, p.21

The four basic options can be summarised as follows:

Option 1. Maintain the current system (with incremental improvements)

What would need to be done?	This option requires the fewest changes. Minor improvements could be made by agreeing a protocol for each type of funding and by providing public information explaining the system.
How long would it take to achieve?	The system is already in place and HSSD and SSD have been working together since the introduction of Income Support to improve communications between the funding departments and with clients
How does balance of costs change?	No change to current balance of cost. States meets 54% of total care costs
Annual cost to States in 2009?	£30 million
Annual cost to States in 2026?	Approximately £60 million
What extra contributions or taxes would people have to pay?	An additional £30 million a year will be needed by 2026. People could be encouraged to take out private insurance to meet their own care costs,.
How much would people pay when they need care?	A variable amount depending on their age, the type of care they are receiving and the care provider.

Option 2. Introduce a fully means-tested system

What would need to be done?	HSSD and FNHC would introduce economic charges for their long-term care services. More people would need to be means-tested. This could take place through the existing Income Support administration.
How long would it take to achieve?	Minor changes to existing laws would be needed but this system could be introduced within 12 to18 months. There would need to be transitional arrangements for individuals currently receiving free or subsidised services.
How does balance of costs change?	The cost to be met by the States would decrease as people who could afford to pay would meet more of their costs themselves. It is difficult to estimate this figure as income information is not collected for this group. The cost may decrease by £3 million a year.
Annual cost to States in 2009?	£27 million (reduction of £3 million)
Annual cost to States in 2026?	Approximately £54 million
What extra contributions or taxes would people have to pay?	An additional £24 million a year will be needed by 2026. People could be encouraged to take out private insurance to meet their care costs.
How much would people pay when they need care?	People would pay as much as possible of the actual cost of their care as they could afford. This could include them using their savings and allowing the States to claim the cost of the care against the value of their former home

	after their death.

Option 3: Provide all long-term care free at the point of delivery

What would need to be done?	This is a major change. A new law would be required to set up the benefit. This would need administration and IT systems to be designed and implemented. As much long-term care is provided by the independent sector, contracts would have to be agreed with care providers to establish standard fees. HSSD and FNHC would introduce these standard fees for their long-term care services.
How long would it take to achieve?	Following a decision to accept this option, it could take two to three years to introduce a law and set up the necessary administration.
How does balance of costs change?	The cost to be met by the States would increase significantly as people who currently pay would receive full assistance with their care costs.
Annual cost to States in 2009?	The total cost of care is at least £55 million and this would all be met by the States
Annual cost to States in 2026?	At least £110 million
What extra contributions or taxes would people have to pay?	At least an additional £25 million a year would be needed. At least an additional £80 million a year will be needed by 2026.
How much would people pay when they need care?	All standard fees for long-term care would be paid by the States. People would only pay if they chose to purchase care at a higher cost.

Option 4. A combined approach, involving a long-term care benefit and means testing.

The cost estimates quoted are based on a new long-term care benefit that covers all long- term care costs. People would still need to pay their own accommodation charges if they needed care in a care home. The UK figure of £267 per week is used for accommodation charges in this Green Paper, but this figure will need to be revised in line with local costs if this option is pursued.

What would need to be done?	This is a major change. A new law would be needed to set up the benefit. This would require administration and IT systems to be designed and implemented. As much long term care is provided by the independent sector, contracts would have to be agreed with care providers to establish standard fees. HSSD and FNHC would introduce these standard fees for their long-term care services.
How long would it take to achieve?	If a decision is made to accept this option, it will take two to three years to draft the law and organise the administration. The similar Guernsey scheme was implemented more than four years after a consultation paper was published
How does balance of costs change?	The cost to be met by the States would increase as some people who currently pay for their own care would receive assistance with their care costs.
Annual cost to States in 2009?	This figure will vary depending on the level of accommodation cost set. Using the UK cost of £267 per week for accommodation, at least an additional £15 million currently met by private individuals would have to be raised
Annual cost to States in 2026?	At least £90 million
What extra contributions or taxes would people have to pay?	At least an additional £15 million a year would be needed to set the scheme up. At least an additional £60 million a year will be needed by 2026.
How much would people pay when they need care?	Everyone in a care home would pay £267 per week towards their accommodation. If they could not afford this, they would get help through means-tested Income Support. People would only pay more than £267 per week if they chose to purchase care at a higher cost.

A number of questions are included in the Questionnaire booklet in respect of the ideas discussed in sections 6 to 9. These questions are provided as a guide to areas in which major decisions will need to be taken in the near future. They do not cover every aspect of this Green Paper and additional comments on any aspect of long-term care are welcome.

Funding

The total cost of long-term care in Jersey is currently in the region of £55 million a year (accommodation costs plus care costs) shared between government (the States) and private individuals. It is not unreasonable to assume that this figure will at least double by 2026 and continue to increase after that. This section considers where the funding could come from to meet some or all of these costs. Whichever benefit system is chosen, the cost to the government will rise in the future.

Competition for funds

In addition to the financial pressures caused by the current economic downturn, there are a number of major long-term funding issues, such as the future of the Social Security pension and the increasing cost of health care, that will be competing for additional public funding at around the same time as the long-term care funding strategy is being explored.

These issues are currently being considered in the Fiscal Strategy Review, which will issue a consultation report in the first half of 2010 setting out options for changes to tax and contribution rates. Choices that are made regarding the funding of long-term care must take into account the additional funding pressures on individuals and on the States in respect of areas such as pension contributions, general health care costs and the replacement of the sewage infrastructure[19].

For example, it will be necessary to increase contribution rates to maintain the current Social Security pension. The recent report from the UK Government Actuary calculated that, if no other steps are taken, Social Security contribution rates will need to rise as follows:

Year	Rate needed to maintain current Social Security pension and benefits[20]
2006	9.0 % - at present, the rate of 10.5% is producing an annual surplus
2016	10.7% - if there is no increase in the rate by 2016 the Fund will start to use up its reserves
2026	13.4% – this is 2.9% above the current rate
2036	16.3% – this is 5.8% above the current rate

Table 5: Forecast of future pay-as-you-go rates for Social Security contributions

A separate long-term care fund

Some countries assist with care funding through general tax revenues. The funding currently available in Jersey is provided in this way. However, other countries have chosen to establish a separate, dedicated fund to which people contribute on the understanding that if they have care needs in the future they will be able to receive benefits without any reference to their assets or income at that time. Guernsey introduced a system of this type several years ago, which is now meeting a range of care costs.

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[19] States Strategic Plan 2009-2014, p.38

[20] The rates quoted are total rates – the current rate of 10.5% is split between employers (5.3%) and employees (5.2%)

Setting up a separate fund means that the majority of people who will not need an expensive care placement during their lives contribute to a fund that will support the minority of people who will have high personal care needs at some point. As it is difficult to predict which of us may one day need a high level of care, the concept of risk sharing (and therefore, cost sharing) could be seen as attractive - everyone contributes in the knowledge that one day they or someone close to them could potentially draw on the fund. However, unlike a pension fund where most contributors receive a benefit in the form of a pension, the majority of contributors to a Long-Term Care Fund will receive no benefit.

Contribution from the States

If a dedicated fund is set up either to meet some or all of the cost of care, the current Health and Social Services funding of £16 million a year used to provide long-term care services could be transferred to the new fund as its contribution to the total needed. At the same time, with the pressures on health costs generally, it may be necessary to introduce user charges in certain health areas, to introduce a new contribution rate or to raise taxation to help fund hospital services.

Alternatively, the funds currently allocated to care could be retained by the HSSD and redirected to meet these increasing health costs. This would mean higher contributions from the general public towards a dedicated long-term care fund, but would reduce the need for separate funding for hospital services.

In addition to the HSSD expenditure, the SSD also makes a substantial contribution to long-term care funding (£14 million p.a.) through the Income Support system which provides means-tested assistance with accommodation and care costs to lower income claimants. If a long-term care benefit is introduced this will affect the amount needed through Income Support.

If care and accommodation are provided free in the future, there would be no need for means testing and the full £14 million currently provided through Income Support could be transferred to the dedicated fund. If a long-term care benefit is introduced to cover the cost of care, leaving an accommodation charge of £267 per week to be met by the individual at the point of care, then the cost of means-tested benefits would reduce by £9 million per annum and this sum could be transferred to the new fund. The remaining £5 million would still be needed to provide means-tested assistance with accommodation charges. The value of £267 per week is only provided as an illustration and if the actual accommodation charge is higher or lower, these allocations would change accordingly.

The estimates given in the following section are based on all existing HSSD care funding being transferred to the new fund.

Raising income tax

Additional funding could be delivered by increasing the take from income tax. This could be achieved by raising the basic rate of personal income tax. This would be relatively simple to implement and easy to understand. If necessary, the additional funds raised could be identified separately from the remaining income tax income (i.e. hypothecated) to create a ring-fenced fund dedicated to meeting care costs.

A 1p rise in the standard rate of personal income tax would raise around £7 million a year. To meet the costs of the different options wholly through increases in income tax would require the following increases:

Increase in rate of personal Income Tax	Option 1. Current system	Option 2. All means test	Option 3. Free care	Option 4. Combined system
2009	0.0 p	0.0 p	3.6 p	2.1 p
2016	1.4 p	0.9 p	6.1 p	4.3 p
2026	4.3 p	3.4 p	11.4 p	8.6 p
2036	7.7 p	6.6 p	17.9 p	13.7 p

Table 6: Personal income tax increases needed to fund long-term care options

Personal income tax is levied on the earned and unearned income of individuals living in Jersey. Increasing the tax rate would bring in additional funds from working age employees, retired people with pension and investment incomes and owners of local companies. As the number of elderly people increases in future, the increase in care costs is likely to rise faster than the general growth in the economy. This would suggest that the amount of income tax allocated to funding care costs would need to increase over time to keep up with the increasing cost of long-term care.

The recent UK Green Paper specifically rejected the concept of funding future care costs through income tax,[21] on the grounds that it would place too great a burden on the shrinking working age population.

Increasing the rate of GST

As an alternative to raising income tax, additional funding could be found through increasing GST. A given percentage of GST could be linked specifically to long-term care funding and used to create a separate, ring fenced fund. GST is levied on most purchases in the Island and is paid by local residents, companies operating in the Island and visitors.

A 1 percentage point increase in the rate of GST would raise approximately £14M. To meet the costs of the options wholly through increases in GST would require the following increases:

Increase (percentage points) in rate of GST	Option 1. Current system	Option 2. All means test	Option 3. Free care	Option 4. Combined system
2009	0.0 %	0.0 %	1.8 %	1.1 %
2016	0.7 %	0.4 %	3.1 %	2.1 %
2026	2.1 %	1.7 %	5.7 %	4.3 %
2036	3.9 %	3.3 %	8.9 %	6.9 %

Table 7: GST increases needed to fund long-term care options

The States has given an undertaking that there will be no increase in GST until 2011 at the earliest.

One-off contribution at pension age

The recent UK Green Paper includes a proposal for people to make a one-off contribution of approximately £20,000 to a fund at the age of 65. This funding stream will automatically increase as the number of people aged over 65 increases. The contribution of £20,000 could be built up by savings during the individual's working

[21] UK Green Paper, p.108

life, through a lump-sum contribution at age 65, or by a deferred contribution set against the value of a property owned by the individual and redeemed following their death. Having made the one-off contribution, the individual would be entitled to receive free personal care for the rest of their life, but it would not cover any accommodation costs if the individual moved into a care home.

Approximately 960 people reached the age of 65 in 2009 and the number of Jersey residents reaching the age of 65 in a particular year is forecast to increase as shown in Table 8[22].

	2006	2016	2026	2035
No of adults aged 65-66	791	1129	1319	1321
Contribution of £20,000 per person	£15.8 M	£22.6M	£26.4M	£26.4M

Table 8: Estimate of number of Jersey residents reaching 65th birthday 2006 - 2035

The majority of people needing care in the next 30 years are already of working age and the requirements to contribute £20,000 on their 65th birthday may be difficult for those now in their 40s and 50s who currently have little or no savings, and limited opportunity to build up this amount.

If this option is to be pursued, it will be necessary to adapt these calculations to the costs appropriate to Jersey, which are likely to be higher. As can be seen from Table 8, the figure of £20,000 would only maintain a means-tested system in Jersey, and the single contribution would need to be much higher to meet the anticipated cost of a long-term care benefit scheme that provided some element of support for everyone.

Ongoing "Social Security" contributions

The approach in Guernsey and some other European countries has been to require all adults to contribute a fixed percentage of their earnings/income to a dedicated long-term care fund. This can include working age adults and retired adults.

In Guernsey, adults of all ages contribute 1.4% of their earnings/income (up to an income ceiling of £69,108) to a ring-fenced long-term care fund. This covers most of the cost of care for about two-thirds of those receiving long-term care in a care home[23]. A payment of £162.40 per week is required towards their accommodation costs.

An alternative approach is taken in Japan. Its system raises contributions only from people aged 40 and over. This approach is justified on the grounds that people of this age may be more conscious of their own long-term care risks and the needs of their ageing parents, and are also more likely to be able to pay[24].

Under the current Jersey Social Security and Health Insurance systems, contributions are raised in respect of earned income from both employers and employees to meet the cost of health benefits, old age pensions, incapacity and maternity benefits. Jersey does not currently collect any contributions from people over pension age.

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[22] Stats unit population model

[23] One-third of care home beds in Guernsey are owned by the States and funded separately.

[24] *Long-term care financing: models and issues* by Mark Merlis (April 2004), p.8

In addition to any increases agreed to fund long-term care, there will need to be increases to Social Security contributions to meet increasing pension costs. Recent forecasts suggest that the current total rate of 10.5% will need to increase to 13.4% by 2026 and 16.3% by 2036 under the existing contribution rules. There are also likely to be increases to the contribution made to Health Insurance costs.

Using the existing Social Security contribution system, an additional 1% contribution from employees (under 65) would raise approximately £13.8million per annum (2008 data). The income ceiling (£42,484 per annum in 2009) limits the contributions from higher-paid workers. As the number of working age adults declines in the future, the total contribution income will fall.

To meet the costs of the options through increases in Social Security contributions from adults aged under 65 would require the following increases:

Increase needed (percentage points) in Social Security type contribution from working age adults	Option 1. Current system	Option 2. All means test	Option 3. Free care	Option 4. Combined system
2009	0.0 %	0.0 %	1.8 %	1.1 %
2016	0.7 %	0.4 %	3.2 %	2.2 %
2026	2.3 %	1.8 %	6.0 %	4.5 %
2036	4.3 %	3.7 %	10.1 %	7.7 %

Table 9: Social Security contribution increases needed to fund long-term care options (working age adults only)

Social Security contributions from pensioners

In countries where contributions are required from those over pension age (for example, Guernsey), these contributions are based on income rather than earnings.

Requiring adults aged over pension age to contribute towards a dedicated fund would help to ease the burden of contributions in the future when the working age population shrinks in relation to the retired population. People in retirement typically have an income that is lower than during their working lives and so the decrease in the number of working age adults coupled with the increase in the number of retirement age adults will lead to a drop in contributions if these are based on a percentage of income. This is likely to lead to the need to increase contribution rates progressively as care costs increase. This is true of all funding scenarios.

If contributions are required from people aged over 65, the percentage contribution rate would be lower and the increases required in future years would be less sharp. The Guernsey long-term care scheme collected £1.8 million (11% of its contributions) in 2008 from those aged over 65. Approximately one-third of Guernsey pensioners have sufficient income to contribute to the scheme and in 2008 they each paid in an average of just under £10 per week.

On the basis that contributions from Jersey pensioners would increase contributions by the same ratio as seen in Guernsey, a 1% contribution rate would raise £1.7 million a year in Jersey from this group. An initial analysis of Jersey income tax data from 2007 confirms that the Guernsey figures are likely to provide a reasonable estimate for the income that could be raised in Jersey.

As the proportion of pensioners in the population increases in the future, the amount raised from pensioners would increase. At the same time, the amount raised by working age adults would decrease. This will mean that the contribution raised from pensioners will become increasingly important over this period.

Based on the estimate of pensioners providing 11% of contributions if a scheme was in place now, the growth in pensioner numbers means that by 2026 pensioners would be providing 18% of contributions and this would rise to nearly a quarter (22%) of total contributions by 2036.

Based on constant income and earnings, the contributions raised by those under 65 would reduce from £13.8 million per percentage point at present to £13.2 million in 2026. At the same time, those over working age currently have a potential contribution of £1.7 million per 1% contribution, which would rise to £2.9 million by 2026.

To meet the costs of the options through increases in Social Security contributions from adults of all ages would require the following increases:

Increase needed (percentage points) in Social Security type contribution from adults of all ages	Option 1. Current system	Option 2. All means test	Option 3. Free care	Option 4. Combined system
2009	0.0 %	0.0 %	1.6 %	1.0 %
2016	0.6 %	0.4 %	2.7 %	1.9 %
2026	1.9 %	1.5 %	4.9 %	3.7 %
2036	3.4 %	2.9 %	7.8 %	6.0 %

Table 10: Social Security contribution increases needed to fund long-term care options (contributions from all adults)

Contribution ceiling

The increases in Social Security rates quoted above could be reduced if the current contributions earnings ceiling was increased or removed completely. At present, the earnings ceiling of £42,484 per annum limits contributions from higher earners.

For example, whereas an additional rate of 1.9% would be needed with the current earnings ceiling to fund Option 4 in 2016, this would be reduced to 1.5% if the earnings ceiling was removed completely. (Contributions from all adults). By 2026, the rates would be 3.7% with the current earnings ceiling or 3% with no ceiling. Removing the ceiling would have no effect on workers earning below the ceiling but would increase the cost of contributions to those earning above the current ceiling.

Contribution from employers and business

The option exists of raising Social Security contributions for long-term care funds from both employers and employees. The Guernsey scheme only collects contributions from employees. At present contributions in Jersey are split fairly evenly with employers paying a total of 6.5%[25] and employees paying a total of 6%[26].

[25] Employers pay 5.3% social security and 1.2% health contributions
[26] Employees pay 5.2% social security and 0.8 % health contributions

Contributions to care costs could also be shared between employees and employers or they could just be paid by employees. The income tax funding example (Table 6) is also based on personal income tax. Requiring contributions from corporate tax payers as well would reduce the rate needed.

Summary of options

Table 11 summarises the additional tax/contribution levels that would be required today to fund each option. It assumes that all relevant HSSD and SSD funding is transferred to contribute towards the funding of care costs. If the HSSD retains its current funding to meet increased health costs in other areas, an additional £16 million per annum would be needed in public contributions. The percentages given in the Table assume that all the additional funding is raised through a single method. It would also be possible to use a mixture of methods to raise the funding required.

	Option 1. Current system	Option 2. All means test	Option 3. Free care	Option 4. Combined system
Total amount required by the States (£ million p.a.)	30	27	55	45
Additional amount needed by the States (£ million p.a.)	-	-	25	15
Increase in personal income tax (percentage points); or	-	-	3.6	2.1
Increase in GST(percentage points); or	-	-	1.8	1.1
Additional contribution, capped at current ceiling (under 65 only) (percentage points); or	-	-	1.8	1.1
Additional contribution capped at current ceiling (all adults) (percentage points)	-	-	1.6	1.0

Table 11: Additional tax/contribution levels that would be required today to fund each option

The average full time wage in Jersey in 2009 was £620 per week. An additional contribution of 1.0% on income/earnings is equivalent to £6.20 per week, and an additional 1.8% is equivalent to £11.16 per week.

Note – All these rates and amounts are estimates based on currently available data. They only give an indication of the income to be raised from each option. Further research will be needed to quantify the exact rates needed.

Whichever option is chosen, initial rates will need to increase progressively over the next few decades as the number of elderly people increases. The shift in the population also means that contributions from older adults will potentially play a bigger role in the future. It is estimated that total care costs will at least double by 2026 and continue to rise until at least 2036.

	Option 1. Current system	Option 2. All means test	Option 3. Free care	Option 4. Combined system
Total amount required by the States (£ million p.a.)	60	54	110	90
Additional amount needed by the States (£ million p.a.)	30	24	80	60
Increase in personal income tax (percentage points); or	4.3	3.4	11.4	8.6
Increase in GST(percentage points); or	2.1	1.7	5.7	4.3
Additional contribution, capped at current ceiling (under 65 only) (percentage points); or	2.3	1.8	6.0	4.5
Additional contribution capped at current ceiling (all adults) (percentage points)	1.9	1.5	4.9	3.7

Table 12: Additional tax/contribution levels that would be required in 2026 to fund each option

By 2036, the rate will need to rise yet further. For example Option 4, which needs a contribution rate of 3.7 % in 2026 will require a contribution rate of 6.0% (all adults) by 2036 and Option 2 will require a contribution rate of 2.9% (all adults) in 2036, up from 1.5% in 2026.

How will rates be set?

Tables 11 and 12 provide an indication of the cost of potential schemes in two different years. In practice, the cost of the scheme will increase gradually each year but the rate that is set to fund long-term care would remain fixed for a number of years. Initially the rate is likely to be set a little higher than is required to meet the costs in the first few years of the scheme. This will build up a small surplus which can be drawn down in the following few years as costs rise. Rates will need to be increased periodically to match the total cost of the scheme in each five to ten year period.

How would the level of a long-term care benefit be set?

Any new care funding system will cover a range of care needs and a mechanism will be agreed for determining and reviewing the benefit available at each care level. These rates will take account of the cost to a commercial operator of providing good quality care services on the Island. It is important to maintain a healthy independent sector by setting fees at a rate that both sustains commercial operators and provides the government with value for money. To facilitate this, a standard care contract will be developed, identifying the services provided and the fee that can be charged. The resident, the care provider and the benefit provider will all have rights and responsibilities under the contract and fee rates will be published.

Top-up payments

If a new long-term care benefit is adopted (Option 3 or Option 4), it is likely that some people will seek a quality of care and accommodation that will exceed the level provided by the standard contract. These people could receive the standard rate of benefit available for their level of care and "top-up" their additional costs themselves.

This could be achieved by allowing an individual to top up their fees, as long as they first made the full payment required to cover their share of care costs (e.g. under Option 4 this would be the accommodation charge). The Guernsey scheme allows for top-ups in this way. Alternatively, if it is decided that top-ups should not be allowed, then those who sought a higher level of care or accommodation could be required to meet the full cost themselves, and would not be eligible to receive any benefit.

Under a means-tested system (Options 1 and 2) top-ups would not be available as people would be expected to use their income and assets to meet the basic costs first. If they could afford the top-up fee, they would not be eligible for means-tested assistance in the first place. Those who could afford to do so could continue to purchase private care as now.

Means testing

Three of the four options set out in this Green Paper include at least some means testing. This section looks at the way in which different types of income and assets could be included in a means-tested system.

The choices to be made in respect of a means testing regime will need to be made in the context of the other support that is agreed upon in a new scheme. If a long-term care benefit is introduced that requires a payment of £250 to £300 per week for accommodation costs, the means testing associated with providing assistance with that payment could be quite strict, taking into account all income and assets.

On the other hand, if most support is provided through means-tested benefits, then a much more generous means-tested system could be appropriate, including substantial allowances for financial and property assets.

How are income and assets dealt with under the current means-tested system?

Under the current Income Support arrangements, an individual seeking assistance with the cost of care fees is subject to a financial assessment of both their income and capital assets. If the capital assets (excluding the value of the main residence) exceed £13,053 for a single person, or £21,636 for a couple (limits as at Oct 2009), then assistance is not provided until the level of savings has fallen below that limit.

An individual with savings below the relevant limit is assessed on the income from their pensions and benefits. Income received from savings is not included in the assessment. The individual is allocated a personal allowance (£30 per week in 2009) to pay for items such as hairdressing, magazines, outings and the balance of their income is used as a payment towards the cost of their fees.

Homeowners can receive assistance from the States with means-tested care and accommodation fees as long as their savings and other capital assets are below the savings limit. When a homeowner is assisted, a charge is taken on the property, so that when the property next changes hands, the money paid out by the States in the form of fees is recouped. The homeowner uses pension income and other regular income to meet some of the cost of the fees and the States makes up the shortfall. Effectively, the States provides an interest-free loan against the value of the property. The UK Green Paper proposes that this system (universal deferred payment mechanism)[27] should be introduced as part of a package of reforms.

The Social Security Department processed130 requests for means-tested financial support with care fees during 2009. Of these, 13 were from homeowners (10%).

In Guernsey, the individual makes a weekly payment (2009) of £162.40 towards their accommodation costs. If an individual cannot afford this, then they can ask for means-tested help. The means-test takes account of their financial assets, but does not include the value of their former property.

[27] UK Green Paper, p.120

Treatment of income

The majority of younger adults needing long-term care will not have had the opportunity to build up investment or pension incomes and are likely to have relatively low incomes whilst receiving long-term care. Older adults needing long-term care are more likely to have investment and/or pension incomes that are not affected by their need for care.

The means testing of income could include the provision of a fixed allowance to provide the claimant with some disposable income and currently £30 per week is paid in this way. The allowance would be set at a fixed amount, at a figure to be agreed. Alternatively, a percentage of income could be retained by the person, so that depending on their original total income, they would have a varying amount of disposable income available. An approach of this type, which was included in the Scrutiny Panel report on long-term care, is described in the next section.

Hybrid system – Partnership Social Insurance

It is possible to introduce elements of means testing into a long-term care benefit provided through a dedicated fund so that as well as providing an agreed minimum level of support to everyone, it also provides a higher level of support to people with lower incomes. This is achieved through staggered means tests. This method, described as partnership social insurance, is favoured by the Scrutiny Panel in their 2008 report.[28]

As an example of how this might work, suppose that a long-term care benefit is introduced at a level such that someone living in a residential care home with total fees of £600 per week is required to make a maximum payment of £400 per week – made up of £133 towards care costs and £267 towards accommodation costs.

For someone with an income below £200 per week, the basic means-tested system would take their full income into account. They would be provided with a weekly personal allowance. The long-term care benefit would provide £400 per week and income support would provide up to £200 per week plus the personal allowance.

For those with incomes between, say, £200 and £600 a week, a second means-test would be applied so that only 50% of their additional income above £200 would be used towards their payment. From the previous example, someone with an income of £500 would therefore make a payment of £350 (£200 + 50% of £300), leaving them with £150 per week disposable income under this system. The long-term care benefit would provide £250 per week to make up the total fee of £600 a week.

Anyone with an income above £600 per week would make the maximum payment of £400 per week and would retain at least £200 a week disposable income. The long-term care benefit would provide at least £200 per week to everyone.

This example is set out in Table 13.

[28] Scrutiny Panel report, p.20

	Hybrid system		Fully means tested system	
Claimant's weekly income	Claimant's payment towards care costs	Personal allowance* /disposable income	Claimant's payment towards care costs	Personal allowance* /disposable income
£100	£100	£30	£100	£30
£200	£200	£30	£200	£30
£300	£250	£50	£300	£30
£350	£275	£75	£350	£30
£400	£300	£100	£400	£30
£500	£350	£150	£400	£100
£600	£400	£200	£400	£200
£700	£400	£300	£400	£300

Table 13: Comparison between Hybrid system and fully means tested system

* If the full income of the claimant is used towards the care payment, they are provided with a personal allowance to meet personal expenses. In this example, the personal allowance is set at £30.

The example shows that there is no difference between the two methods for someone with an income of less than £200 per week or more than £600 for week. Between £200 and £600 per week, the staggered system requires a lower payment from the individual.

This is not intended to be a realistic example of actual income and payment levels; it is only illustrative. If this option is adopted, careful consideration will need to be given to the incomes at which different levels of means testing are applied.

The advantage of the hybrid approach is that it provides a more generous means-test to those who do not have sufficient income to cover the full payment themselves, but who do have a certain level of income. It would allow them to retain some of that income rather than contributing it all towards their care costs. Under this scheme, claimants with a higher level of income would be better off than they would be under a simple means-tested system. However, such a scheme would involve more complicated administration with more claimants needing to submit income and asset details.

The cost of this type of scheme would vary depending on the levels chosen for the different types of support. By reducing the amount of long-term care benefit available to everyone, it would decrease the total cost although some of this saving would be needed to fund the more generous benefit levels paid to lower income claimants.

Home ownership

Home ownership is an important goal within our society. The rate of home ownership in Jersey is comparatively low, at 52%[29], compared with England[30] (68%)

[29] Housing Needs Survey 2007 in Jersey in Figures 2008 (p.34)
[30] Housing in England 2007-08, September 2009, p.11

and Guernsey[31] (72%). The States Strategic Plan includes a commitment to introduce schemes to encourage more home ownership[32].

In recent years, home ownership has brought with it substantial financial gains. The UK Green Paper summarised the situation, noting that:

'The generation currently in their 50s and 60s, or older, has benefited in particular from massive increases in property prices. In 2004, people over 60 held £932 billion in equity in their homes. This is likely to have dropped slightly with the fall in property prices, and we know there is very wide inequality among older people. But the group of people over 60 remain the wealthiest generation that this country has ever seen.'[33]

Property values locally have risen considerably in recent years and the UK analysis is likely to hold true in Jersey.

The decision as to how the value of a main residence should be treated when considering support for long-term care fees has already given rise to strong emotive arguments.

Treatment of assets

Concerns have been expressed that people requiring care in a care home will need to use all their savings and assets to pay for their care.

UK statistics suggest that approximately 70% of people who move to a care home, live there for no more than one year. Only a very small proportion of people need care for more than two years. Assuming a two year stay, the total cost for an individual under a fully means-tested system (Option 2), could be

Nursing care @ £1,200 per week: £124,800 for 2 years; or
Residential care @ £750 per week: £78,000 for 2 years

If a long-term care benefit is introduced, the amount to be paid by the individual could be set at a fixed rate, whatever their care needs. For example, Option 4 described earlier requires a payment of £267 per week to cover accommodation costs. This would require a total payment of £27,768 for a two year stay in a care home (residential care or nursing care).

The cost to be borne by the care home resident under the different funding options can be compared with the value of Jersey property. In the third quarter of 2009 average (mean) property prices[34] were recorded as:

Type	Average value
1 bedroom flat	£222,000
2 bedroom flat	£303,000
2 bedroom house	£414,000
3 bedroom house	£538,000
4 bedroom house	£692,000

Table 14: Average property prices in Jersey – third quarter 2009

[31] Guernsey Household Expenditure Survey 2005-06, Technical Report p.25 (2001 Census figure)
[32] States Strategic Plan 2009-2014, p.30
[33] UK Green Paper, p.90
[34] Jersey House Price Index 3rd quarter 2009 – Stats Unit

In most means tested systems, assets that can be easily converted into cash (deposit accounts, stocks and shares) are considered first. Other assets that would be harder to realise as cash are often also taken into account, but sometimes a loan is provided to remove the need to realise these assets in the short term. This mainly applies to property (including the value of the main residence), but it can also be relevant to fixed-term bonds and deposits which would incur penalties if cashed in early.

If means testing is included as part of a new funding scheme, a certain amount of assets could be disregarded so that the individual can keep any assets they have up to this level. This amount could be set at say, £20,000. All assets above this level would be included in the means assessment and would need to be used towards the payment of the share of the care costs to be borne by the individual. Home owners seeking assistance with care costs would be required to agree to a charge on their property which would be redeemed following the death of the owner, and their partner (if appropriate). The States would then provide a loan in respect of the care fees. Alternatively a private provider could fund the loan through an equity release scheme.

Another approach is to allow individuals a much larger capital allowance, say £300,000. This would ensure that many smaller properties would be completely exempt from the means-test and owners of larger properties would be guaranteed to retain at least this amount, regardless of the total cost of their care fees. This method might be appropriate if a fully means-tested system (Option 2) is introduced. For those without properties, it would protect almost all their savings and investments. For the small minority of homeowners who accumulate very large care fees over several years, this system would guarantee that they would retain a significant proportion of the value of their property.

These two approaches can be considered against Options 2 and 4 to give the following scenarios:

	Option 2 - All means-tested – individual pays as much as possible towards full care fees	Option 4 - Combined system – individual makes standard payment (£267 per week) towards accommodation costs
Allowance of £20,000	Lowest cost to be met by States funding: some of the value of property will be used to meet care costs. Savings of non- property owners likely to be used.	Reduced costs to be met by individual so smaller loan needed against property. Savings of non-property owners may be used but will last longer
Allowance of £300,000	More generous allowance protects owners of small properties. Owners of larger properties will pay towards care costs up to a limit. Savings of non-property owners very likely to be exempt.	Highest cost to be met by States funding: owners of smaller properties protected completely. Owners of larger properties only pay some of their own costs. Savings of non-property owners very likely to be exempt.

Table 15: Comparison of different capital allowances

In both examples above, there is no difference in the treatment of property assets and other types of asset. Differentiating between property assets and non-property assets could lead to families manipulating assets to seek to gain the maximum benefit from the new system. In particular, exempting property assets from the

means-test, but including other assets, could encourage older people to retain ownership of the family home, when a move to a smaller, more convenient property (with a subsequent release of capital) could maintain their independence for longer. Similarly, older people choosing to retain ownership of large properties in order to claim the maximum possible benefit could also slow down the release of family-sized homes to younger families in need of accommodation. On the other hand, home ownership may be seen as qualitatively different to the possession of other types of asset and it may be considered that the value of the main residence should likewise be treated separately from other assets.

Private insurance to pay for care fees

If the system adopted for funding long-term care includes a significant amount of means testing, private care insurance could become an attractive proposition for those wishing to protect their assets or maintain a higher element of disposable income when they are in care.

The UK Green Paper raises the prospect of people taking out commercial insurance to fund any potential long-term care needs. However, it admits that without some level of compulsion, take up is likely to be low. Even in countries where such a market is more established, take up is unremarkable. France has optional private long-term care insurance, but take up is only 3% of the population. In Germany, the take up is 11%, but this includes individuals who are required to use private insurance because they are exempt from the compulsory social insurance scheme.

At the moment, the market for such products in the UK is not developed and the prospect of commercial long-term care insurance products emerging in the short term seems unlikely. Realistically, unless the UK government supports a major expansion of private insurance in this area, it is unlikely that insurance companies will develop products that would be available to Jersey residents.

If the UK government does adopt policies that encourage private insurance, a system of auto enrolment could be considered locally. People would be automatically enrolled into an insurance scheme that had been approved by the government when they reached a certain age. They would be at liberty to opt out of the insurance if they did not wish to pay for it.

Auto enrolment is a simple method of encouraging people to adopt a policy favoured by the government – many people would remain in the scheme due to simple inertia. In this way, a reasonable proportion of the population could be covered by private care insurance. However, as stated above, it would be difficult for Jersey to implement this policy without a number of commercial products already being available in the UK market.

Eligibility

Contribution record

If a long-term care benefit is introduced and funded through an insurance-based fund, then access to the benefit could be limited to those who had made contributions to the fund. It would be necessary to consider the situation of adults who would never be in a position to make contributions. The position of people requiring care soon after the scheme becomes operational who will not have had an opportunity to make any contributions would also need to be addressed.

Assessment of care needs

The assessment of care needs is an important factor in determining eligibility. There are two main methods used to assess access to assistance with care costs.

An objective level of care needs can be set, whereby everyone with at least a certain level of needs receives assistance. Alternatively, a selection process can assess claimants and allocate assistance on a priority basis to ensure that the budget is not exceeded. Both methods are used in Jersey at present.

Access to means-tested support for residential care is controlled through a placement tool[35], which sets an objective test as to the level of care needed. This test is carried out by health care professionals. The only limiting factor on the number of people to be supported at any one time is the number of residential care beds available in Jersey. At present, there is a good supply of residential beds and access is therefore not an issue, so all who are judged as needing a residential care bed are allocated one. The disadvantage of this method is that it is difficult to control the budget as the cost of additional placements is currently always met.

In contrast, assistance with nursing care costs is currently rationed as a limited number of nursing care beds is available through public funding. People referred for a placement are assessed by an HSSD team to determine their priority for a bed. Rationing support through a fixed number of placements ensures that budgets can be controlled. However, where the demand for nursing care beds outstrips supply, this can lead to patients being kept in hospital longer than necessary (bed blocking), carers struggling to support an individual in a setting that is no longer appropriate to their needs, or people deciding to fund themselves in a private nursing care home at considerable additional cost to themselves. The Guernsey system uses a panel to control access to its long-term care benefit in this way.

It will be important to establish a single method of assessing care needs to identify eligibility for any new system.

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[35] The placement tool is a set of standard questions covering the mental and physical condition of the individual. It identifies care needs according to a numeric scale, which ranges from 0 (no care needs at all) to 12 (very high dependency nursing care needs).

Range of care establishments

Not all establishments registered under the Nursing and Residential Homes (Jersey) Law 1994 fit the typical picture of a care home. There are a number of establishments registered as care homes for under 65s that deal mainly with people who are homeless and/or have addiction problems.

- Roseneath – a charity that provides accommodation to homeless vulnerable adults, some with additional care needs, which can include addiction problems, health or mental health problems or learning disabilities.
- The Shelter Trust is a charity offering accommodation, support and a way forward for homeless people in Jersey. At present, accommodation and support is offered from three sites around St Helier.

Silkworth Charity Group consists of three charities which provide a tailor-made programme of treatment for those suffering and affected by drug or alcohol addiction. The range of care starts with the rehabilitation programme at Silkworth Lodge, through to ongoing support in its half-way houses.

The people living in these establishments have a range of needs but the majority do not have personal or nursing care needs sufficient to justify a placement in a traditional residential or nursing care home. Living in a home that is registered under the Nursing and Residential Homes (Jersey) Law 1994 will not be a sufficient condition in itself to merit assistance with care needs. Assistance will be available to those who satisfy the care needs eligibility test.

Age

The majority of people needing assistance with care needs are elderly. However, there will also be younger adults who have ongoing care needs. Some of these younger adults will have had a condition since birth and there will be a number of working age people who acquire care needs following an accident or illness.

Older people are more likely to have built up assets and pension income during their lives and so will gain more from the introduction of a long-term care benefit that does not take income or assets into account. Younger adults often have limited income or savings and are more likely to qualify for assistance through existing means-tested benefits. Most countries allow all adults with a certain level of care needs to receive benefits.

Residency

Access to the long-term care benefit could also be limited according to other criteria. For example, it could be a condition that the individual has lived in Jersey for a number of years prior to applying for the long-term care benefit. Most Social Security benefits are available after paying contributions for six months in Jersey. Income Support benefit is available after five years' continuous residence; under the previous parish system, people aged over 55 needed to have ten years' residence in Jersey to receive assistance (unless they were Jersey born). The Guernsey long-term care scheme requires people to have lived in Guernsey for at least five years at some point **and** for at least 12 months immediately before claiming the benefit.

Conclusion

This Green Paper seeks to raise public awareness of the challenges and difficult decisions facing the Island as it grapples with the question of how to fund the growing cost of long-term care. At the moment the annual cost is put at around £55 million a year; by 2026 this cost is estimated (at current prices) to have doubled. Other countries are experiencing similar dilemmas and in the UK a similar consultation exercise was recently held on the funding of long-term care in England.

The content of this Paper has included: setting out the reasons why long-term care funding has become an issue; explaining current arrangements – for care and funding – and the cost; suggesting some possible ways forward, including how the necessary additional funding could be raised; and discussing how assets and income could be treated in any funding solution.

Ultimately, there is no escaping the fact that the amount of States' financial support available will be linked to people's willingness to fund it. The greater the level of support provided by the States, the greater the financial contribution required from the population at large. The contribution that people are prepared to make in this way will determine the extent of States funding available above and beyond that required to assist those who cannot afford to pay for basic care from their own resources.

The Minister for Social Security is keen to receive the considered views of all sections of the community – from the young and not so young; from homeowners and non-homeowners; from those on low incomes and those who are well off. A range of views will help inform the deliberations on what happens next – a White Paper setting out the Minister's preferred solution will be published in 2010.

To stimulate discussion and encourage views on the way forward, four main options are suggested in the Green Paper. Each one creates a different balance between States funding and payments made by people at the time they need care.

The options broadly are to:

Option 1 - maintain the current system
Option 2 - move to a fully means-tested system for all long-term care
Option 3 - provide all long-term care free of charge at the point of delivery
Option 4 - introduce a new long-term care benefit that meets some of the cost of care, while retaining means testing for those unable to meet their share of the cost.

The paper includes indicative costs for each option if it was in place today and shows how each option could be paid for – for example, by raising the level of Income Tax or GST, or by raising Social Security contributions which, for the first time, could extend to over 65s. The money raised could be set aside in a separate fund that could be strictly dedicated to paying for long-term care costs.

Whichever option is chosen – those detailed above or any other – the cost to the States will rise as the number of elderly people increases and the costs of care grow. And this is happening at a time of other funding pressures that will ultimately be borne by the taxpayer, including pensions, healthcare spending and infrastructure improvements.

Any new system for funding long-term care has to be seen to be fair, easy to understand and affordable to all parties. Ultimately, we all have a responsibility for ensuring high-quality care for vulnerable young adults and older members of society.

Contributing to funding is a burden that we all have to shoulder – how much and in what form may become clearer following the responses to this Green Paper.

How to respond

There is a separate summary booklet and questionnaire covering the issues raised in this paper. These documents are available from the department, Cyril Le Marquand House, the public library and parish halls. The questionnaire is also available online at www.gov.je

Written comments may be sent to:

Long-Term Care Consultation
Social Security Department
PO Box 55
Philip Le Feuvre House
La Motte Street
St Helier
JE4 8PE

A number of public meetings and presentations will be held between January and March 2010. These will be advertised in the local press, and details will be posted on the www.gov.je website.

The consultation will close on 31 March 2010.

Appendices

Appendix 1 - Long-term care funding in other countries

Information in this section is taken from 'Reforming Long-term care: Recent lessons from other countries' by Caroline Glendinning and Nicola Moran from the Social Policy Research Unit at the University of York, published in June 2009. [36]

Germany

Long-term care insurance (LTCI) was introduced in Germany in 1994/95. The introduction of LTCI led to a substantial reduction in the number of people between 1994 and 2002 dependent on social assistance to fund their care.

LTCI is compulsory for the whole population; non-employed family members are covered by the head of household's contributions. Around ten per cent of employed people belong to private care insurance schemes.

People with care needs of all ages – including disabled children – are eligible. Eligibility is determined by a medical assessment of 'care dependency'.

Eligible beneficiaries can opt for a cash payment (at a lower value); in kind professional services (worth nearly twice as much) or a combination of the two. Each option is paid at one of three grades or levels, depending on the assessed level of 'care dependency' of the beneficiary. At each level, benefits for people in institutional care are higher than the in kind service benefits for people at home.

Despite its significantly lower value, the cash payment option has always been much more popular, although there has been a small gradual increase in the number of beneficiaries opting for the in kind service option or for mixed awards of cash and services.

From 2000, the long-term care insurance was in operational deficit to the tune of about euro 400 million in 2002 and euro 500 million in 2005. This was caused by: continuing high levels of unemployment, which reduced the level of funds coming into the scheme; a higher proportion of LTCI beneficiaries receiving institutional care; and a gradual increase in the proportion of recipients opting for the higher level 'in kind' service option.

Some flexibility was built into the scheme by the deliberate accumulation of a financial surplus in the first year (contributions were collected from January 1995, but the full range of benefits was only paid from July 1996).

The fixed ceilings of the levels of insurance benefits meant that the real value of insurance benefits was eroded as the costs of professional care rose. Gaps in care therefore arose.

The first structural changes to long-term care insurance came into force in March 2008. Contribution rates rose from 1.7% to 1.95% of gross salary for people with children (of any age) and from 1.95% to 2.2% for people without children. The contributions of unemployed people are paid by their unemployment insurance. Retired people are also liable to pay.

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[36] A copy of the report (Working Paper no. DHP 2318) can be obtained by visiting the Social Policy Research Unit's website at www.york.ac.uk/spru

Among the other changes implemented in 2008 were that benefits could be drawn after two, instead of five, contribution years. Benefit levels were increased, with further increases planned in 2010 and 2012 and new provisions for family carers also introduced.

The Netherlands

Everyone with income over a minimum threshold and up to euro 29,543 per annum contributes a percentage of income (13.55%) to an insurance scheme through payroll tax. Taxpayers not in employment pay their contributions through their tax assessments. Some revenue from general taxation is also contributed. The average monthly contribution for someone on an average income is now euro 320. There are also income-related co-payments/charges for the institutional or home care services that people use.

Cash personal budgets are available, calculated according to the number of hours of care needed, but with a 25% reduction applied on the grounds that that independent and informal care provision does not incur the same overheads as formal provider agencies. Personal budgets can be used to fund home nursing and personal care in line with the needs identified at assessment.

A funding shortfall has been addressed by increasing co-payments for middle and higher income groups and tightening eligibility criteria. The government has also set out how much care family members could be expected to provide for each other free of charge.

Japan

Japan has the most rapidly ageing society in the world. In April 2000, Japan introduced a compulsory, public long-term care insurance programme. Everyone aged 65+ is eligible for benefits, as are people aged 40+ with age-related conditions (eg stroke or Parkinson's disease) based on a standard assessment of disability and care needs.

Public funding for long-term care insurance is split 50:50 between taxes (national, regional and local) and income-related premiums, which are paid by everyone aged 40+. The contributions of older people are deducted from their public pensions. Those aged 40 to 64 pay a supplement to their health insurance premium; the supplementary premium is split 50: 50 between employees and their employers. In addition, all those using long-term care insurance pay a standard co-payment of ten per cent of the cost of their services (excluding care management) regardless of their income level.

Because of concerns about variable and discretionary local decision-making under previous arrangements, the design of long-term care insurance attached great importance to the creation of transparent, uniform eligibility criteria. Factors such as income, assets or access to family care are not taken into account.

Benefits are all in the form of services, not cash. (This is intended in part to reduce the burden on unpaid family care givers, particularly daughters-in-law.) The level of benefit depends on the level of assessed care need. The volume of community-based services (home help and day care) has increased substantially following implementation of the scheme, and has grown faster than institutional care provision.

Concern about rising costs has seen measures instituted that have included: removing most accommodation costs in care homes from the long-term care

insurance coverage – and now income-related. Benefits for those in the two lowest eligibility categories (those with the lowest level care needs) have been restricted and replaced by preventive health promotion interventions, mainly diet and exercise programmes delivered in day centres that also offer social activities. For people at the two lowest levels of eligibility who receive only domestic help and other support with daily living, there is a new 're-ablement-focused' emphasis on the active involvement of the user.

Australia

Overall, about 75% of total resources for aged care expenditure come from general taxation raised by federal and state/territory governments, with the remainder from user contributions.

The government has contained costs by a series of reforms introduced during the 1980s – the Aged Care Reform Programme – that restricted the growth of spending on care homes and encouraged the development of alternative home and community-based services.

Later, policy debate focused on shifting the balance of responsibility for aged care from the state to the family and from the public to the private sector.

The 1997 Aged Care Act brought in a series of financial and regulatory changes to residential care that were intended to limit government commitments to financing aged care and increase the responsibilities of service users to pay for their own services.

The Hogan report of enquiry (2004) into the pricing of aged residential care advocated tighter means testing of older people's incomes and other changes to increase the financial contribution of service users. The intention was that the Australian government's role would shift increasingly from ensuring universal coverage of aged care services to the provision of a residual safety net for those without the necessary income or assets.

Denmark

Denmark adopted a policy of community- and home-based care in the early 1980s. Services are funded from a combination of local taxation and subsidies, block grants and equalisation grants from central government. Domiciliary care, meals on wheels services, home nursing and rehabilitation services are all free of charge, regardless of the number of hours' care received or the income of the recipient. In care homes, user fees are only levied on accommodation charges.

In Denmark the focus appears not to be on funding per se, but on introducing choice of service providers.

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Lessons for the reform of care and support in England

Drawing on their analysis of the five countries, Glendinning and Moran suggest a number of principles for the reform of care and support in England:

- 'A single, integrated funding stream for long-term care is easier to manage and sustain than multiple, fragmented funding streams. Separate funding streams for health services and long-term care also help the sustainability of both.

- Central government has a major role to play in generating and managing resources for care; setting clear eligibility criteria; and sustaining political support for an area of public spending that will come under increasing pressure over coming decades. Local government has important roles to play in conducting assessments and ensuring an appropriate range of services is available.
- Income-related insurance contributions (or hypothecated taxation) may be an acceptable, and progressive, way of raising revenue. Additional revenue can be generated from income-related co-payments. Political acceptability may be enhanced by the inclusiveness of universal schemes in which all contributors have a stake as potential beneficiaries.
- It is feasible to design systems in which older and younger disabled people enjoy the same entitlements and benefits. Age-related inequalities may be difficult to resolve subsequently. However, universal eligibility criteria need to reflect appropriately the help needed by people with cognitive impairments.
- Benefits in the form of cash payments are likely to encourage or support informal care-giving, but additional social protection measures for carers are also required. Benefits in the form of cash payments may also create new difficulties in guaranteeing quality employment for carers and quality care for those who need it.'

Appendix 2 – The funding of long-term care in Scotland

Scotland has a policy of providing personal and nursing care which is free at the point of delivery. This dual policy has been in place since 1 July 2002.[37]

Personal care is available without charge for everyone in Scotland aged 65 and over who has been assessed by the local authority as needing it. Free nursing care is available for people of any age.

If you are assessed as needing these services, the local authority will pay fixed rates of £153 a week for personal care and £69 a week for nursing care or £222 a week if someone requires both. Payments are made directly to the care provider. People still need to pay their everyday housing and living costs in the care home.

Therefore, it has to be stressed that long-term care is not entirely 'free' in Scotland. People still have to pay for their accommodation and related costs. It does not address specifically the problem of people eventually having to sell their own homes to pay for care if their assets exceed the upper capital limit.

People living at home can receive free personal care if aged 65 or over and are assessed by the local authority as needing it. They then receive the care free of charge or can ask the local authority for a direct payment so they can arrange and purchase the services themselves. They may be required to pay for any non-personal care they need such as lunch clubs, meals on wheels and help with shopping and housework. If they need those kind of services their local authority will carry out a financial assessment to determine whether they are able to meet or contribute towards the cost.

In adopting its policy, Scotland broke ranks with the rest of the UK and went beyond the provision of free nursing care that currently applies in England. Its stance stemmed from the recommendations of The Royal Commission on Long-term Care that reported in March 1999. The Commission identified three broad components of charging for care in a care home: nursing care; personal care and accommodation and related costs – often referred to as 'hotel charges'. It said that nursing care should be provided without charge; personal care should be available after assessment, according to need and paid for from general taxation; and the other components should be subject to a co-payment according to means.

One of the reasons given for adopting free personal care was that it was right in principle, because it removed the discrimination against older people who had chronic or degenerative illness and needed personal care in line with medical and nursing care in the NHS, where the principle of free care based on need was almost universally applied and accepted.

The main practical effect of making personal care free of charge was to reduce the cost of care for the 7,000 or so Scots in residential care who were 'self-funding' and in doing so removed the anomaly between health care, which was free, and personal care which was means-tested.

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[37] A useful document summarising the experience of free personal and nursing care in Scotland is 'Independent Review of Free Personal and Nursing Care in Scotland' – a report by Lord Sutherland, April 2008

Appendix 3 – The Guernsey Long-term Care Insurance Scheme (LTCI)

Guernsey's scheme for funding long-term residential care is currently (2009) funded by a 1.4% social insurance levy, paid by everyone – employed and unemployed, working age and retired. This entitles all payees to a weekly benefit towards the cost of the fees in a private residential or private nursing home.

To qualify for the long-term care benefit, individuals have to be assessed as being in need of care that could be provided in a private residential care or private nursing home. This care needs assessment is carried out by a healthcare professional. They pass their findings to the Needs Assessment Panel at the Board of Health. The Panel decides on the type of care best suited to the individual's needs and issues a certificate. There is an appeals mechanism.

In practice, the Needs Assessment Panel allocations are made largely according to what bed provision is available at the time. The funding is always available through the LTCI scheme, but bed places sometimes are not. If allocation is not possible, then needs continue to be met in the community until a bed becomes available.

To be eligible for the scheme, the individual has to have, at any time, lived in Guernsey or Alderney for a continuous period of five years and lived on the islands for at least 12 months immediately prior to claiming long-term care benefit.

Once an individual is assessed as needing care, the rate paid by the States of Guernsey (effective 5 January 2009) is £359.94 a week in a private residential home and £672 a week in a private nursing home. The sum the individual has to pay to the care home out of their own funds – the weekly co-payment – is £162.40. If an individual does not have the wherewithal to pay it (even if they own their own home), then assistance is available through Supplementary Benefit. (In January 2010, the maximum residential care benefit will rise to £367.15 a week; the nursing care benefit to £685.44 a week; and the co-payment to £165.62 a week.)

If an individual agrees to take a room for which the charge is more than the value of the co-payment plus the maximum benefit paid under the scheme, then the extra must be paid from their own funds or by a third party.

It does not cover institutional placements owned by the States – Guernsey provides both residential and nursing care places through States-owned facilities. If the person is living in a residential home run by the States, the person just pays the weekly co-payment – they do not need to claim long-term care benefit.

All employees currently contribute 1.4% of their earnings, up to £69,108, to the ring-fenced long-term care fund. The self-employed, non-employed under 65 and non-employed over 65 also contribute to the fund. Employers do not contribute.

However, from January 2010 this contribution rate will change for some groups. This follows from plans to increase the upper earnings limit on which employees are liable for contributions to £115,128 a year over five years. These increases are intended to increase contributions to the Guernsey Insurance Fund – not to the health service fund or the long-term care fund – therefore, the contribution from employees and self-employed to the long-term care fund is being reduced from 1.4% to 1.3%. The figure for the non-employed under 65 remains at 1.4% as the introduction of an allowance on income will result in a reduction of contribution income from non-employed persons over 65, not an increase.

The overall contribution rate for non-employed people over 65 is increasing from 2.6% of income to 2.9%. However, this is being accompanied by the introduction of an allowance on income of £6,177 a year. Their contribution to the long-term care

fund will rise from 1.4% to 1.6% from January 2010. The combined effect for this group is that lower income contributors will pay less and higher income contributors (£60,000+) will pay more.

In 2008, £16.2million was paid into the fund from contributors. With benefit and administration expenditure of £12.31m for the year, the Fund had an operating surplus of £3.89m.

The Social Security Department reported in July 2009 that: '…the operating surplus remains relatively large in proportion to expenditure. This reflects the strategy for this particular fund…that is to have a front-loaded contribution rate of 1.4%, which should hold good for a minimum of 15 years, assuming no fundamental change in the range of benefits. This strategy involves the accumulation of reserves to provide an investment income to supplement future contribution rates.'

When the scheme began in 2003, the financing of the scheme included a general revenue grant from the States which was equal to 12% of contribution income collected for the fund. This grant ceased from 1 January 2007.

This scheme followed the introduction in Guernsey of a Specialist Health Insurance Scheme that involved the collection of contributions from people over 65 as well as the working population. So the Insurance Fund concept was by no means an alien one to the people of Guernsey. The Guernsey long-term care scheme replaced a myriad of means-tested systems that were considered unsatisfactory.

The Guernsey scheme does not cover the cost of home care, but it does cover clients of any age, not just older people. It is likely that following a review next year, a broader definition of long-term care may be adopted. If agreed, the expanded definition would enable long-term care benefit to be paid for care in community settings, such as extra care housing schemes. The Social Security Department notes that: '…if fundamental changes to the nature of the long-term care insurance scheme result from States approval of a new strategy for older people, then there will certainly be a requirement for an increase in the contribution rate for long-term care.'

Appendix 4 – The funding of long-term care in England: a summary of the current arrangements

In England, social care is means-tested and subject to local council control. The exact level of financial help a person will receive with long-term care will vary according to where they live. There is an initial care assessment, but each council has its own budget and decides which of the four needs bands it will fund.

Means testing
How much the applicant has to contribute is based on their savings and capital, and income. The local council only looks at the individual's financial situation, not that of their partner or any other relative. If they hold savings jointly with someone else, it will be assumed that their share is 50%.

Savings and capital of over £23,000 make the applicant ineligible for financial help from the local council. If someone has savings below this level, but above the lower savings limit of £14,000, then savings between the two limits are converted into an assumed weekly income using a formula – for every £250 or part of £250 above the lower savings limit, £1 a week is added to the individual's income.

Councils take into account any income from savings, pensions and state benefits (including pension credit). Half of any occupational or personal pension is disregarded as long as at least half of the pension is passed on to a wife, husband or civil partner who is still living at home. England abolished the 'liable relatives' rule in April 2009, so a partner is not liable to pay towards their care.

If someone is assessed as needing nursing care, they get help with the costs of this, regardless of their finances. The NHS contributes to the cost of nursing care at £103.80 or £142.80 a week.

How the main residence is treated
If an individual owns their own home, its value is usually treated as capital. However, if the individual's husband, wife or civil partner lives in it then its value will not be counted as capital in the assessment. All in all, there are a number of exclusions, such that if someone is living there then it is excluded from consideration. The local council cannot force someone to sell their home and may sign up to a deferred payments agreement that may involve a legal charge being placed on the property. In the meantime, the council is effectively providing an interest-free loan, to be paid back when the property is sold.

In April 2001, the UK Government introduced a 12-week property disregard which means that in every case the value of the home is not taken into account for the first 12 weeks of a permanent stay in a care home. If someone wants to enter a home that is more expensive than the amount the council would usually expect to pay for someone with a particular assessed need, then they can arrange for a member of the family (but not the spouse) to pay the top up. The council can agree to pay this and add it to the deferred contribution that will be repaid from the sale of the property.

This summary is based on Help the Aged Information Sheet 10 'Paying for your care home' available online at www.helptheaged.org.uk

Appendix 5 -'Shaping the future of Care Together' – a Green Paper setting out the UK government's vision for a National Care Service for England (July 2009)

'To put the National Care Service on solid foundations, we need to make sure that it is based on a funding system that will meet the demands of the future. We believe that the current approach to care and support is not sustainable. Over the coming decades, more people will need long-term care and support, and so the cost of providing care and support will rise. Society is going to need to spend more on care and support, and we need to decide where the funding is going to come from – whether from the state, from individuals or from both.' (Page 96)

Summary of the funding options considered in the Green Paper

The Green Paper considers five funding options. To meet its vision for a new National Care Service, each funding option has to be: fair; simple; affordable and sustainable; universal; and help people live their lives the way they want to. Two of the options fail this test so they have been ruled out.

It is important to note that all five options are only considering ways to fund the cost of care. This does not include the cost of accommodation or board and lodgings in a care home. Under any of these proposals, this aspect would continue to be means-tested.

1. *Pay for yourself* – no support from the state, not even for those with no income. **Ruled out** as would leave some people without the care and support they need and therefore unfair.

2. *Partnership* – everybody who was assessed as having a care need, would be entitled to have a share of their basic care and support costs paid for by the state – this could be, say, a quarter or a third of their care costs – regardless of their wealth or income. People with less money to contribute would get a greater share paid by the state. Those on the lowest incomes would continue to get all of their care free. Others would have to spend their savings or release the value of their homes.

   Positive aspects of this 'partnership approach' that shares costs between the individual and the state are that everybody would be receiving some funding (unlike now) and people would only be paying something if it turned out that they needed care (aside from their contribution through general taxation).

   However, if they owned their own home (and no family member living in it) or had savings, they would still have to contribute and this could amount to large sums if in a care home for a long time.

According to the document, a 65-year-old in England will need care that costs on average £30,000 during their retirement, so someone who got the basic offer of a third or a quarter paid for might need to pay around £20,000 or £22,500. Many people would pay much less, while some who need high levels of care and support would pay far more than this and would need to spend their savings and the value of their homes.

The Green Paper states that: 'We believe that the principle of partnership is right. The state should provide everyone with at least some help with their care costs. So we think that the partnership option should be the foundation of the new system.' (P.110)

Everybody assessed as requiring care would get something – but potentially it wouldn't stop the risk of having to pay high costs towards their care, although these payments could potentially be deferred.

To safeguard against this, complementary options are suggested.

3 *Insurance system* – with 'partnership' as the basic model (ie everyone would get something) the state could help people to prepare to meet the additional costs that they would have to pay themselves through insurance.

The government might work with the private insurance industry to develop a range of simple standard products or, alternatively, set up an insurance system backed by the state.

Currently very few people take out private insurance against needing care – partly because care and support costs are so high that insurance premiums are too. Insurers may also choose who they insure.

A state-backed insurance scheme – membership would be voluntary: people choose to be in it – either by paying the premium in advance or committing to pay when they died. In return, they would have their basic care and support provided for free.

The state's role could be limited to just setting up the scheme, but it could also promote it and encourage people to join. To work really well would need as many people in the scheme as possible as it shares the risk so everyone pays less.

This would give people who have worked and saved all their lives the opportunity to protect their assets.

However, there is an acknowledgement that the experience of other countries suggests that comparatively few people would choose to take up the private insurance. The more active the state's role in promoting insurance, the higher the level of coverage that can be achieved.

As an indication of costs, people might need to pay around £20,000 to £25,000 to be protected, compared with the average cost of care of £30,000. This could be paid before or after their retirement or after their death.

4. *Comprehensive*
Everyone over 65 who could afford to would pay into a national scheme or pot. If they then needed care they would get all their basic care and support for free. Some people would pay in and be fortunate enough never to call on it for support. How much people would pay would be according to what they could afford, perhaps linked to their level of savings or assets.

It could be a single figure that people paid – so people knew how much they would have to save for. Those who could not afford to pay into the system would have their contribution paid for them by the state.

The state would also put in existing funding from taxes used for social care and any disability benefits that were integrated and would use this to support the costs of everyone's care.

Because everyone was in the system, and all the state funding for care and support could be used to reduce the costs, people would be able to pay less than their likely average costs.

Once they had paid into the system, they would be able to protect their savings and would not have to run down the value of their homes to pay for care and support.

The comprehensive system would be cheaper for people paying into it than the insurance system as everybody would be making a contribution.

The system could be flexible, with many ways to pay.

Disadvantage is that everyone would have to pay in, whether or not they actually needed care and support. With the variation in what people have to pay for care and support, some would pay in more than the actual costs of their care and support, while others would pay much less. In the current economic climate, people may not want to take on the extra commitment of paying for care and support.

People might need to pay around £17,000 to £20,000 to be protected under a scheme of this sort, compared with the average cost of care for a 65-year-old of £30,000.

How would people pay?
If held savings, could pay their contribution up-front as a lump sum when they retired. Might delay their retirement, defer State pension for a few years and use the money to pay into the scheme

People could pay in affordable instalments throughout their retirement or could defer the whole payment until they died and then pay it from their estate, or a combination (eg a lump sum from their pension and partly in instalments throughout their retirement).

5 *Tax-funded*
Although in an earlier consultation many people said that fairest approach was an NHS-style system where the full costs of care and support are met through taxation, this has been **ruled out** because it would require a significant increase in the tax that people already pay, as it would be funding all care and support, including the parts that people currently pay for themselves when they need it.

The system would be universal and the simplest, but disadvantage is that it puts a large part of the burden of paying for care and support on people of working age. Given demographic changes, this pressure will be on a shrinking proportion of working age people. In 2007, the number of people aged over 65 became greater than the number under 18 for the first time.

Because the majority of people benefiting from a reformed care and support system will be pensioners, it is fairer to think about more targeted ways of bringing in extra funding, rather than placing a lot of the burden of the system on people pf working age. Have to bear in mind that in 2004, people over retirement age collectively held £932 billion in housing assets. By contrast, people of working age have struggled to get on the property ladder due to rising house prices, and often pay higher mortgages.

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The treatment of accommodation costs

If people were living at home, people would be expected to buy their own food, pay their own bills and pay their own rent or their own mortgage. If they pay these 'accommodation' costs in their own home, then they would be expected to continue to pay for these elements in a care home. Therefore, funding to meet elements such as the costs of cleaning the room, providing food and doing laundry would continue to be means-tested. These are a normal part of everybody's life, regardless of whether they have a care need or not – Green Paper says fair to expect the majority of people to cover these costs themselves. (People with assets under £23,000, or whose spouse or partner is still living in the family home, currently receive state support towards their accommodation costs.)

According to the Green Paper: 'Over an average stay of two years, someone could spend around £25,000 on their care costs and about the same on their accommodation costs.'

However, it is acknowledged that government can do more to help people in the way they pay these costs and a universal **deferred payment mechanism** for residential care and accommodation costs is proposed. This means that when someone chooses to go into a care home, they will not have to pay the full costs immediately. Deferred payments are already offered by many local authorities as a way for people to allow the cost of care and accommodation in a care home to be charged upon their estate when they die, rather than having to go through the process of selling their home when they need residential care.

Green Paper says option to defer payment for residential care and accommodation costs in residential care should be available to everybody.

Reference: *Shaping the future of care together* HM Government Green Paper (July 2009). The key chapters informing the summary above are chapter 5 'The choices around funding' pp85-93; and chapter 6 'Funding options' pp95-127.

http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_102338