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THE FUNDING OF COMMUNITY CARE: WHO IS RESPONSIBLE?*

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The question posed in the title has provoked enormous debate, commanded millions of written words and challenged political ideology and economic values. This response is not from an economist or a political scientist but from a recipient of concerns raised by both the general public and professionls. The issues also affect me personally, as it does all of us in society in one way or another. This paper considers the current complexities of funding, highlights some moral and practical dilemmas and suggests possible solutions. As older people are the biggest consumers of community care, the paper will concentrate on this group but the needs of other vulnerable people—those with physical disabilities or mental health problems will also need to be addressed.

The present challenge to the status quo is that a welfare state is no longer practicable, though it has been described as popular and deeply entrenched. Its presence permits a vague sense of justice; the national health service and universal pension are considered inviolable.[1] Furthermore it is held that the country cannot afford it's continuation.

William Laing in his book *Financing Long Term Care* points out that 'whether the state can afford to pay for long-term care is a political question, the answer to which is in no way pre-empted by economics. There is inevitably a clash of ideologies—those who have understood and wish there to be a universal benefits system based on contributions and those who believe that the trend should be towards private provision and means testing'.[2] The crux of the argument is whether the nation can afford to maintain with a comprehensive welfare system the population of older people which is growing dramatically. We are constantly urged that the old are a burden and that the timebomb of caring for them is about to explode. How much of this is fact and how much of it is scaremongering?

DEMOGRAPHIC ASPECTS

The projected increase in the number of people over the age of 60 will reach a peak in 2036 but at present only 6% of the older population live permanently in residential or hospital accommodation, and predominantly these persons are over 75 years of age (Fig 1). Most older people live independently in their own home, many of them alone. Some sense of proportion has to be kept about the dependency of *all* older people whilst at the same time looking at practical ways of resolving how care in the community should be funded. The trend is known about and this affords an opportunity to plan. It is essential that a view is established that these demographic changes do not pose an intractable problem

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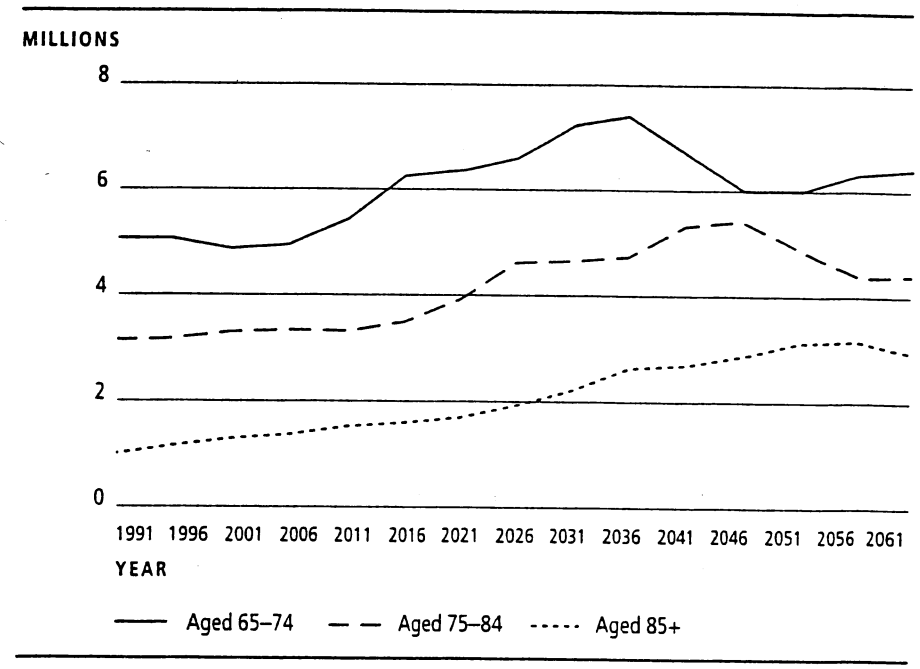

Source: Government Actuary's Department as published by Age Concern England[2]

FIGURE 1

United Kingdom elderly population, 1991–2061, principal projection

with the consequence that no action is taken and a crisis created for our successors.

The definition of community in Chambers dictionary includes: 'Common possession' 'Agreement' 'People having common rights' 'The public in general' or 'Body of persons in the same locality'.

I believe that society has lost its understanding of the need for common rights, agreement and recognition of a 'body of persons in the same locality'. These are core principles in the provision of health and social services, but there is a tendency for them to get lost in semantics and catch phrases which do the services a disfavour. Hansard reports an MP who, when asked what the difference was between *community care* and *care in the community*, replied that community care was for those who lived in the community and care in the community was for those who were discharged from hospital! This interpretation reduces the understanding of both care and community.

Changes in policy have defined and redefined the boundaries in which health and social care have to operate to the extent that the interdependence between them is lost, and adverse effects have occurred on housing and social security issues. A crude attempt to track resources into the system that provide care for older people is outlined in Fig 2. Systems run in parallel between care provision by health authorities and by local authorities in the face of budget restrictions, national and local politics and free market philosophy as to what charges local authorities are empowered to make. These complicate matters for the recipient of

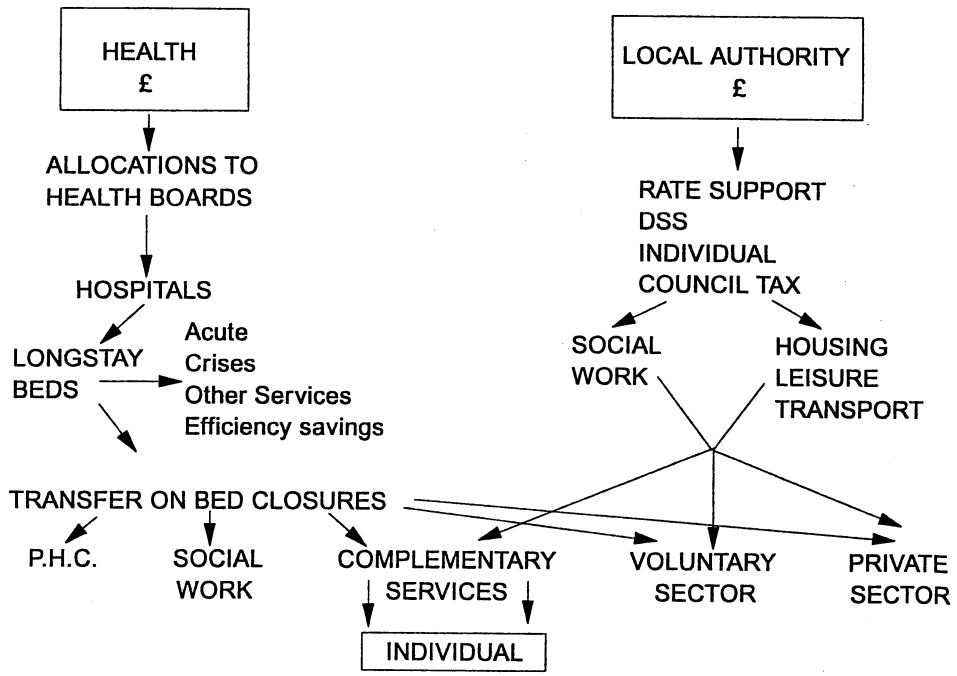

FIGURE 2

Continuing care (older people) tracking financial resources

care and bewilder older people, many of whom hold the view that they have already paid their way to security in old age.

FINANCING CARE

Funds are allocated to health and social care from central government. Local authorities raise additional finance but it should be acknowledged that a significant proportion of funding is contributed by individuals. The services provided by the health and social services of the local authority are seen as separate and their interdependence rarely acknowledged, perhaps to the detriment of the best use of available resources. A possible scenario envisages the hospital service reducing the number of long stay beds and increasing the beds available for acute services; as a consequence more services must be available in the community to enable people to live at home in security, comfort and independence.

Each service is faced with a myriad of conflicting choices and priorities in a context of budget reductions. The Social Work Services have a reduced budget because the allocations through rate support grants to local authorities have been cut. A choice is made to cut back on homecare services either in time allowed or the range of services, or additional home care charges are made which have a self-rationing effect. One possible response is referral to the general practitioner because of inability to remain safely independent. The choice follows of inappropriate admission to an acute ward (the most expensive option) or to residential care, neither of which might be the preferred option of the individual who in the community care legislation has been promised choice.

Joint planning and funding exist at a local level but the process has to start

earlier with a realisation of the impact on each of the services of taking decisions in isolation. A constant plea for extra resources is not appropriate alone but rather an imaginative and integrated approach between all departments—health, housing, social services and social security—to achieve the most beneficial outcome for the individual and society. The theme of interdependence is strongly represented in the literature at the present time as also is the concept that isolating budgets, in whatever service or authority, is not an efficient use of resources nor a helpful way of providing integrated services.

THE IMPORTANCE OF INTERDEPENDENCE

One example of the importance of the need for interdependence can be found in a review of the system and the role of community care legislation. The costs of residential accommodation were escalating because the housing conditions of a number of old people were inadequate with poor heating and the need for repairs, the costs of which were outwith the incomes of those concerned. The solution had been to transfer people into residential accommodation. If the real costs of required repairs had been taken into account against the on-going costs of maintainance in residential accommodation, repairs to hundreds of houses could have been achieved and more people could have retained their independence while the housing stock was maintained.

This problem of 'short-termism' which besets effective planning and management in public services has a consequent knock-on effect for the independent providers of services, including the voluntary sector. Is it still not time that we moved away from 'the Treasury system of controlling spending by annual reviews. This ensures that budgets are allocated late and frequently adjusted downwards after the financial year has begun'.[1] A recognition of the importance of interdependence between health, housing, social care and welfare benefits should be a clear aspect of any policy on paying for care related to a move away from short-term expedients in budget allocations; it also has to be seen in relation to our industrial base, job security and stable incomes. But can society afford to pay?

A body of research demonstrates that known trends do not support the view that funding long-term or community care is beyond the bounds of affordability on the current financing arrangements unless significant changes in medical technology extend our life expectation significantly. Nor do we know whether the future older population would be more or less healthy than the current one? This view is supported by William Laing in *Financing Long Term Care* and also by the recent report from the Family Policy Studies Centre, both of which point out that the proportion of gross domestic product (GDP)spent on long term care of older people would have to rise from 1.5% in 1992 to 3.5% by the time demand peaks in the year 2051 in order to maintain the services at today's level and standards.[2,3] Forecasts have been made and trends identified to plan and implement plans to manage these changes through the next 40 years. Table 1 shows the distribution of the costs of care. Laing contends that if 70% of care continues to be publicly funded the State would find its financial commitment to the long term care of older people rising from a little over 1% of GDP in 1992 to 2.5% in 2051. Whilst paying for care is an obvious challenge, Laing believes that it would be wholly misleading to represent it as an impending crisis

TABLE 1

Distribution of the costs of publicly funded care in NHS and care home settings

		£m
NHS expenditure:		
Geriatric/psychogeriatric beds		1,496
Independent nursing homes		97
	Total	1,593
Local authority expenditure:		
Residential (Part III)		1,090
Independent & nursing homes		129
	Total	1,218
Costs recouped		345
	Net	873

requiring a major adjustment to the economy when, what is required, is a political decision.[2]

THE PRESENT FINANCE OF CARE

The responsibility for providing care is shared between the NHS and the local authorities. The contentious issue is that care within an NHS setting has been free to date but charges have always been made for residential care provided by a local authority. With the emphasis away from hospital provision, more people are being expected to pay for care and this is exacerbated by the more recent introduction of home care charges. The potential cost to the individual has increased but as levels of service and costs are at the discretion of each local authority significant differences can be demonstrated in different areas.

One aspect which rarely gets the recognition it deserves is the contribution of carers. If the hours put in by unpaid 'informal carers' were costed at £7.00 per hour based on local authority pay rates, the total annual cost has been calculated at £32.5 million. The role played by carers within the family by voluntary groups in the community must be acknowledged. Withdrawal of any of this support, although highly improbable, would have catastrophic effects on the ability of the services to manage.

There are several options for funding community care—social security with or without means tests, partial social provision, private provision voluntary or compulsory. The questions remain, is it affordable and by whom?

Many commentators believe that it is possible for the State to continue to finance health and social care given the willingeness and time to plan. The key advantage of public funding is that it spreads the risk across a much wider population, it is more equitable and does not penalise the thrifty or disadvantage those on low incomes. It provides the security people expect and to which they have contributed. There could however be a much clearer method of funding specific items such as pensions or care costs within a tax system. An illustration is the national social insurance scheme recently introduced in Germany where the

costs of long term care are paid by all current workers and employers provide individuals with a 'known personal fund'.

The disadvantage of private provision, part or wholly compulsory, is that it is difficult for the average family to afford. A recent BBC 'Panorama programme' showed an insurance company representative calculating the costs of privately financing health care, pension, redundancy cover, etc. The costs to a family who wish to achieve anything like comprehensive care, health and an adequate pension was in the region of £1,000 per month. This approach would create gaps in the ability of individuals to pay and in gaining access to services, and consequently create very sharp divides in society.

CONCLUSION

There needs to be confirmation of the principles on which care services should be provided, a greater recognition of the interdependence between services, opportunities to plan long-term and to review the necessity of short-term practice and a recognition for the grossly underestimated contribution by unpaid carers.

Who should be responsible? The voting population needs to stand on its principles if as a society we want to achieve security in old age and care throughout our lives. There needs to be a better understanding of community so that there is more acceptance of common rights and agreements for mutual support. Care should not be a football kicked about between one political ideology and another and between the differing expectations of national and local government. It is an area that would benefit from consensus politics. After all that was how the Beveridge reforms were introduced. As individuals we have to influence whether the decisions are collective or individual. Whatever way it is viewed, ultimately paying for care is the responsibility of the individual citizen.

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