Dilnot Recapped

Bridging the Valley of Despair | Restoring the Intergenerational Contract

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Introduction

It is incredible that Westminster isn't talking more about how to fund and facilitate long-term care for the elderly over the coming decades when it may indeed be the biggest expense any of us incur. In 2010, the Dilnot Commission was tasked by the coalition government to find a solution to the problem. A year later, their presented their solutions included:

- A cap on individuals' contributions towards lifetime social care costs of between £25,000 and £50,000 (with the commission recommending £35,000 as the ideal cap), beyond which individuals would be eligible for full state support.
- The means-tested threshold, above which people are liable for their full care costs, should be increased from £23,250 to £100,000.
- National eligibility criteria and portable assessments should be introduced to ensure greater consistency.
- All those who enter adulthood, with a care and support need, should be eligible for free state support immediately rather than being subjected to a means test.

> *Dilnot's recommendations simply have to be made to work if the intergenerational contract is to be restored.*

However, the government did not implement the recommendations as suggested. Instead, it raised the proposed cap from £35,000 to £72,000 which means asset protection is focused on a much smaller and wealthier section of the population. Residential costs were also excluded from the cap, meaning that longer living people could find their costs spiral wildly out of control – a massive disincentive towards saving during a person's working life.

Two major factors threaten the intergenerational contract whereby the bulk of funding for long-term care is funded by the current generation of income tax payers. The first, is the gradual increase in longevity, especially of the over 75's and the over 85's. The age distribution for admission to care homes is narrow, so gradual increases in life expectancy can mean large increases in the total number of admissions to long-term care far in excess of growth in real wages, tax base or economic growth.

The second, is a combination of low interest rates, government approval of property price rises, and a burgeoning population in England which has shifted the asset base away from those of working age to those in retirement and for all but the highest decile. This asset base is reflected overwhelmingly in the form of equity in bricks and mortar.

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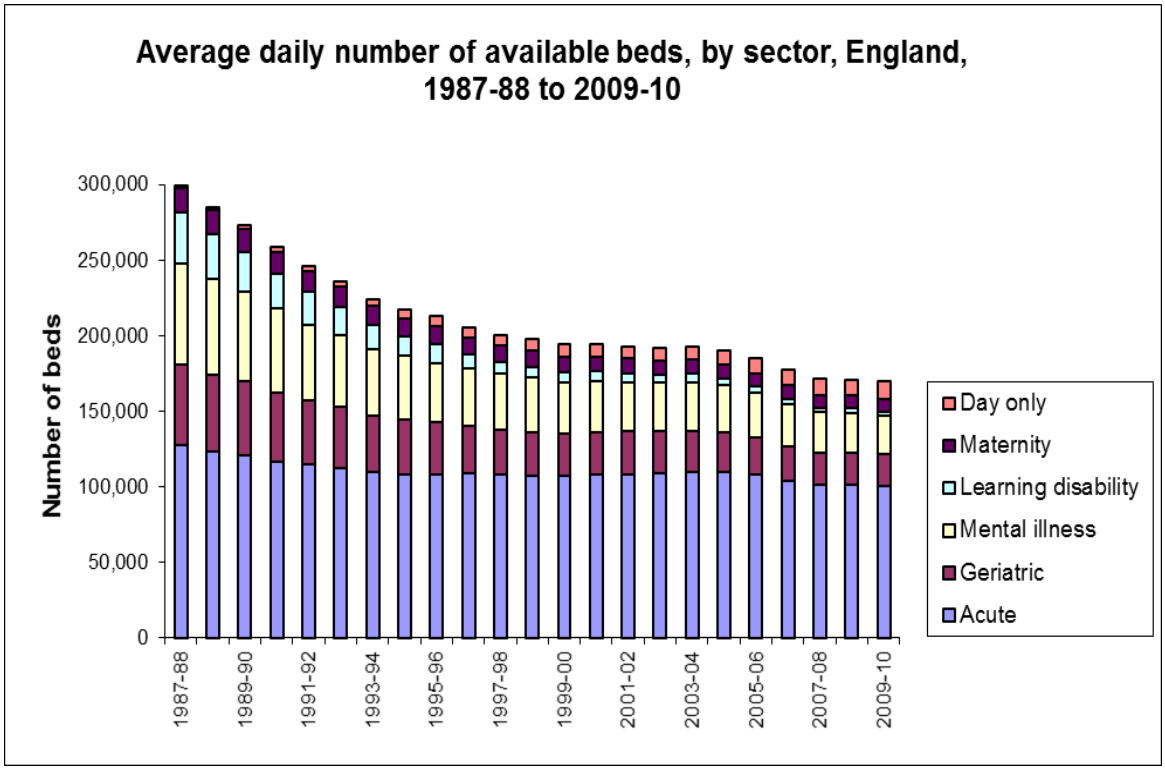
Since the Dilnot Commission published its report, it has been assumed that the Government now has an answer to care funding and that we can now more confidently plan for dignity in old age at a price within our means. Neither is true, not by a longshot. Dilnot's recommendations simply have to be made to work if the intergenerational contract is to be restored. This paper suggests a variant of the current proposals that seeks to close this gap.

The Crux of the Matter

Means testing is long established in funding care home places. Until the Dilnot commission was convened, the UK had operated a funding mechanism almost unchanged since 1948 wherein the state would pay the cost of care once a resident had depleted their assets down to a certain level. This provided a powerful disincentive to save and to plan financially, especially given the complete lack of protection from catastrophically high costs based on high care needs and/or an unexpectedly long stay.

A need to protect against such high costs has been identified many times, especially by the work of James Lloyd from the Strategic Society Centre. There has been an understandable reluctance towards a tax-funded Universal Care Service given the increasing debt and tax burden on the young, and growth in capital assets owned by retirees — overwhelmingly in the form of property.



Moreover, attempts by local authorities to avoid the costs of nursing care have led to cases of elderly patients being left in hospital, which is often not the most suitable place for them to be. Inevitably this leads to the problem of 'bed-blocking' in hospitals, which we hear so much about in the papers.

There have been marked changes to long-term care since the 1980's, further compounding the problem. Hospital inpatient beds for the elderly have fallen by over 60% since the late 1980's despite the elderly population booming, especially those over 75.[1] There has been a decline in care homes provided by local authorities and the NHS who are desperate to save money, and a huge expansion in the role of the private sector driven in part by the increase of funding by the DHSS, and later local authorities, to meet care costs.

National Health Service | Local Care Service

There is a fundamental difference in the local democratic oversight and degree of funding between a fully tax funded, needs based NHS controlled by central government, and social care which is funded by local government on a means tested basis.

This becomes a serious challenge to the NHS and local government. The problem emerges when the taxpayer pays for a patient in a hospital bed yet a resident pays to stay in a residential home or nursing home. This creates perverse incentives to delay placement to a care home despite the weekly cost being almost half that of medical ward because the NHS is fee free and long term care isn't.

It also means that patients who have come into hospital from a residential home due to physical decline continue to pay for residential care until their bed is given to the next prospective resident on the waiting list, or the home refuses to take the resident back. It is not acceptable to leave a residential home bed unoccupied for several weeks, and there is also no statutory duty on the care provider to ensure a resident is escalated from a residential to nursing home if their condition requires it.

The difference in costs between residential and nursing homes is considerable, and the NHS nursing payment seldom covers the true cost of the care delivered. Families have the perverse incentive to keep their relative in a residential home for too long depriving them of the care needed, and increasing the likelihood of the transfer happening as the result of a hospital admission. A large proportion of admissions to care homes are directly from hospital or another care home.[2]

Demographic characteristics	Local authority	Residential place	Private	Nursing place	All places
Number of individuals	206	243	865	1124	2438
Age group	2	3	3	4	3
65 to 69					
70 to 74	8	9	8	10	9
75 to 79	15	12	15	19	17
80 to 84	31	24	26	26	26
85 and over	45	52	48	41	45
Sex					
Male	31	28	25	32	29
Female	69	72	75	68	71
Source of admission					
Domestic household	44	40	35	18	28
Sheltered housing	8	10	8	2	5
Residential care	7	8	10	12	10
Nursing home	<1	2	2	4	3
Hospital	39	39	44	63	52
Other	0	2	2	2	1
(8 weeks before admission) Lived	67	62	62	38	51
Lived with others	29	31	24	35	30
In hospital	3	4	7	16	10
In resid./nursing home	1	2	6	11	7
Elsewhere	0	1	<1	<1	<1
(8 weeks before admission) Owner	24	26	23	22	23
Rented from LA/NT/HA	60	56	50	44	49
Privately rented	8	7	10	5	7
Other	3	3	3	2	3
Not living in household	4	8	14	27	19

This “valley of despair”, the transition between hospital and home, and from residential to nursing home, harms the elderly. When care provision is delayed, patients become disorientated and frightened by their stay in hospital. Delayed hospital discharges, which occur while funding is arranged and rehabilitation potential is assessed, are expensive. A hospital stay for an elderly patient can exceed £1,100 a week. This falls squarely on the taxpayer’s shoulders, mounting up to a staggering cost.

The Valley of Despair

The cost to elderly patients of transition from one care environment to another must be minimised, thus removing perverse incentives to delay. A further barrier to a smooth transition is the lack of any real continuity of care between the NHS and care homes. Staff members are different, immiscible, and belong to organisations with very different management structures. This needs addressing.

Isolation drift in practice occurs under these circumstances and can contribute to a downward spiral in care quality as poor care demotivates committed competent staff. The sector is characterised by high staff turnover rates. Nurses are accountable to care home providers, which creates a conflict of interest that deters whistleblowing. Shallow pools of staff likewise make identifying a whistleblower easy and this further discourages the reporting of poor practice.

Health and social care merge do not at the interface between hospital and care home, but between care home and nursing provision. Recognition of this is fundamental to proposing a solution that can break down this boundary while ensuring rising care costs, rather than hotel costs, are met without disincentive. Scotland has achieved this partially through a commitment to universal free nursing care. The value for money from the provision of universal free personal care appears far less convincing, given the large number of people with means to pay receiving it at home.

Scrapping the NHS nurse contribution, and instead staffing nursing homes directly with NHS staff would lower transaction costs and remove the risk of under provision due to rent seeking behaviour from managers using the contribution as a general top-up fee. Rotating nurses between elderly wards and nursing homes will prevent isolation drift, encourage modern practice and provide a means to raise concerns within a much larger staffing pool.

Underwriting the first month of residential or nursing home care, to be reclaimed at a later date, would allow for patients blocking-in beds in hospitals to be transferred to care homes much faster, not only saving money and beds, but also ensuring their care needs are assessed in the environment they will be given.

A High Cap May As Well Be No Cap

The main feature of Dilnot’s proposals is the cap on care costs, raised to £75,000 by the coalition government. Not only is this cap too high to provide the social justice it was intended to, but also lulls the public into a false sense of security. It is not a cap on the total cost of care and does not protect anyone from catastrophically high care costs which can effect anyone, but in practice effect only very few.[3]

Health and social care merge not at the interface between hospital and care home, but between care home and nursing provision. Recognition of this is fundamental to proposing a solution.

A high “cap” of £75,000 negates the concept of a cap in the first place; this was meant to protect asset depletion for a large number of retirees when set at £35,000 as Dilnot suggested. The new “cap” costs the taxman less, but is far less equitably spent, protecting the assets of a much smaller number of people.

This paper proposes a slight increase in contributions based on the accessible assets of the care resident in return for reducing contributions based on need, and ending all contributions after a

finite period of 5 years to protect the very frail and those living longest from catastrophic care costs.

Crucially, scrapping the cash payment for nursing care, and instead offering full NHS nursing care which treats every nursing home as a virtual ward, would ensure rising nursing needs do not impact the resident financially. It could prevent poor practice from isolational drift and a limited ability to keep practice up to date, with hospital matrons acting as a local and discrete form of care inspection. Bridging the valley of despair between hospital, residential and nursing home care offers productivity gains for the NHS, especially to front end services like A&E and acute medicine.

Real families are multigenerational, and conservative. An increasingly indebted working age population is being squeezed between funding childcare and tertiary education for their children while the retired population has enjoyed unprecedented capital gains over the last 30 years. Ensuring we meet the needs of our own long term care without relying on the state is perhaps the most family friendly policy we can apply, while protecting all from catastrophic care bills.

Capping Asset Depreciation

Dilnot has proposed to cap care costs at £75,000, a cap that will rise with inflation. Assuming a long-term inflation rate of 2.5% the annual rise in this would be equivalent to £35 per week in care costs. But the cap assumes basic living costs of up to £240 per week are covered by the resident, which means it will take considerably longer to reach this cap, and at a much higher cost than one would expect.

> *A high 'cap' of £75,000 negates the concept of a cap in the first place. Asset protection is focussed on a much smaller and wealthier section of the population.*

There is also a cap based on the depletion of capital, not on the real cost of care. Income is not included in what is really a cap on the rate of depletion of assets, but this unfairly hurts those whose wealth lies in their pension, rather than their property. The maximum depletion rate is set at £1 per week for each £250 of accessible capital; the difference between a lower threshold at which the state funds the care costs fully, and a higher threshold at which support is withdrawn. This accessible capital is approximately £100,000.[4]

This flat rate does not change according to length of stay, meaning that a very higher number of residents will pay very little towards their care while a small number will face much higher bills. It is almost impossible to predict which individuals will face these huge care costs through living longer, thus raising anxiety for everyone.

The table below shows that 10% of residents survive in a nursing home beyond 6 years, yet 70% do not survive three years; of those, half survive the first 12 months.

Lloyd has proposed a lump sum pre-insurance payment to protect against catastrophic care costs. A one-off cost at the commencement of long term care would appear at first sight a reasonable and simple way of insuring against high long-term costs, but this is much more the case for those in the seventh centile than the third.[5]

Cumulative Percent	5	10	15	20	25	30	35	40	45	50
Length of stay to date (years)	0.068	0.153	0.252	0.397	0.548	0.729	0.916	1.109	1.326	1.603

Cumulative Percent	55	60	65	70	75	80	85	90	95	
Length of stay to date (years)	1.877	2.178	2.556	2.962	3.444	4.090	4.883	5.906	7.801	

Preloading care payments by increasing the maximum rate of asset depreciation to £1 for every £200 by 20% for the first 3 years of care, would allow the Dilnot proposals to insure against catastrophic costs by fully funding care costs after five years in care. This would provide an absolute maximum care cost to be estimated and make such costs much easier to insure on the market.

Recommendations

- The cap on care costs is a deeply flawed concept and should be scrapped, not least as it doesn't include living costs, so it is not a true reflection of the cost of long-term care. Instead, the cost of care will be transferred to the taxpayer after five years, removing the threat of catastrophic care costs from the elderly.
- Asset depreciation to be slightly raised during the first three years of care by 20%.
- Scrapping cash payments for nursing care in homes, bridging the valley of despair between hospitals, nursing care and residential care. Funded care should include up to 16 hours of care assistant time per week, the average number of care assistant hours per week in a residential home. This will protect people who need above average hours of care from catastrophic costs.

References

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