A to Z

Mapping long-term care markets

Resolution Foundation

Executive summary

The Resolution Foundation and long-term care for older people

The Resolution Foundation is an independent research and policy organisation. Our goal is to improve the wellbeing of low earners in today's mixed economy. We aim to deliver change in areas where this income group is currently disadvantaged by producing new research and actively engaging in the policy-making process.

We have chosen to focus our efforts on the issue of long-term care for older people for three main reasons:

1. **Long-term care presents particular challenges for low earners**. We define low earners as those who are mainly independent of state support, but who earn less than median incomes.[1] As such, this group are on the cliff-edge of means testing eligibility - the majority are not eligible for free or subsidised state care, and yet their relatively low incomes make care costs a significant financial burden. This group are likely to spend a larger proportion of their weekly budgets on care than both higher and lower earners.
2. **Long-term care is a complex mixed market of funding and delivery**. It is driven by public and private funding and delivered by private, public and third sector organisations. The Foundation is particularly interested in how low earners fare in such systems and how mixed market solutions can be developed to improve outcomes.
3. **Long-term care is becoming increasingly important as a political priority**, with 2008 likely to be a crucial year in setting the direction for reform. The Foundation believes the Government's recent commitment to a Green Paper and the ongoing Transformation Programme provides a real opportunity to build the framework for sustainable reform of long-term care in the run up to a General Election.

What have we done so far?

In February 2008, the Foundation published *Lost: low earners and the elderly care market*. This report summarised the findings of a literature review, focus groups and interviews carried out on our behalf by Deloitte, as well as a survey we commissioned from YouGov. The research sought to explore low earners' perceptions and experiences of long-term care. Key findings included:

- Low earners are more likely to be both carers and care users.[2]
- They have a deep sense of unfairness regarding long-term care, believing the system punishes those who work and save to prepare for old age.
- They are convinced care is declining in quality and becoming less affordable.
- The complexity and lack of guidance in navigating their care choices is their single most pressing concern.
- They would like to see the majority of people receiving free or subsidised care, and say they are willing to pay more tax in order for the state to deliver such an outcome.

Findings from our latest research

This report describes and assesses the market of long-term care based on analysis conducted by Deloitte for the Resolution Foundation. As such, it provides an overview of how long-term care functions and whether it is fit for purpose.

The first section describes and explains the market functions of long-term care in a mapping exercise, before assessing how well it operates according to two criteria - efficiency and fairness. This second criteria has been included to take into account that the long-term care market is not a private market, but one which deals with a social good, and so ought not to be purely "efficient" to the detriment of being "fair". The third section of the report then reflects on some key developments that will have a significant impact on the market in the near future. This illustrates the fragile nature of the current market, and the pressing need for sustainable reform.

The market map:

- With defined demand for care (based on need) and formal supply (which we limit to residential and domiciliary care for the purposes of this study), long-term care functions at its highest level as a market.
- It is a market for a "social good" (i.e. care), which the government has a duty to provide for those in need if they cannot afford it themselves. As such it does not operate as a pure private market - its efficiency must be balanced with progressive and re-distributive characteristics.
- Long-term care functions as a mixed market of funding and supply. Public and private funding is used to purchase care from private, public and third sector suppliers.
- Needs and means eligibility and commissioning create a complex interface between supply and demand.
- It is highly localised, and could be seen as a collection of diverse local markets, each with their own supply and demand characteristics.

[1] We define this group as those individuals who earn less than median incomes but who are receive less than 20 per cent of their incomes from state benefits. Households earning between around £14k and £23k and individuals between around £7,300 and £12k would fall into this group.
[2] YouGov Poll for Resolution Foundation, sample size for the survey was 2,006 adults. Fieldwork was undertaken from 3-5 December 2007

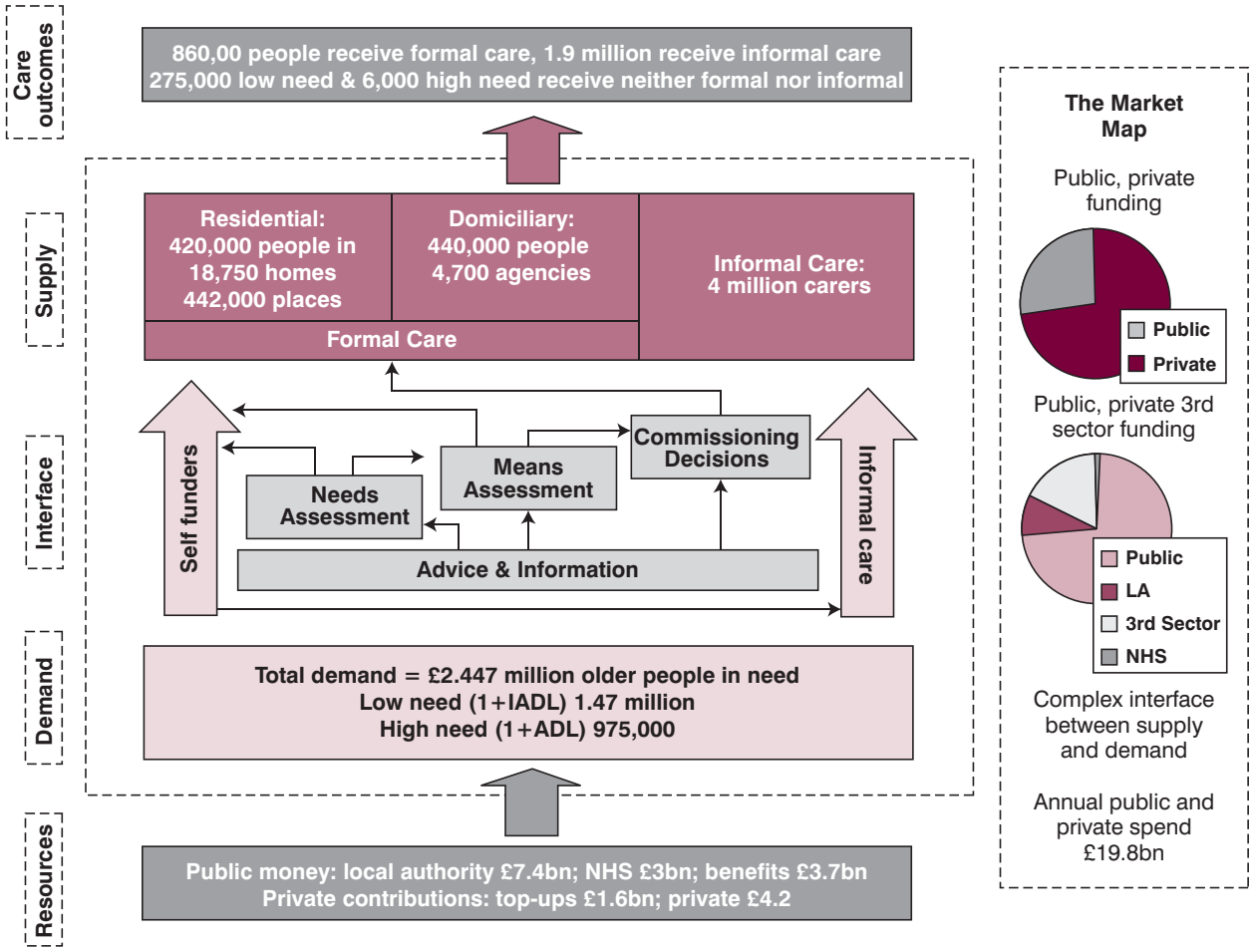
- Alongside the formal supply of long-term care in the residential and domiciliary sectors, a significant proportion of demand is met by informal care. Those receiving informal care may do so by choice, though a proportion rely on long-term care as they have been excluded from the formal care market.
- Care markets interconnect with a range of other markets and systems contributing to older people's well-being, including housing, transport, and benefits.

Key facts:

- Local authorities spend £7.3bn on formal care every year. Individuals spend £4.2bn in private funding every year, plus £1.6bn in top ups.[3]
- The two main formal care sectors - residential and domiciliary care - are worth £19.8bn.[4]

- 2.447 million older people are assessed as having some form of need for care.[5]
- There are 18,570 residential homes in the UK catering for 420,000 older people.[6]
- There are 4,700 domiciliary agencies in operation delivering 4.5 million hours of care a year to 440,000 older people.[7]
- 1.9 million older people receive informal care from 4 million carers.[8]
- Informal care represents around 65 per cent of all care delivered. 25 per cent is local authority funded formal care and 10 per cent is privately purchased.[9]
- Around 40,000 long-term care policies are currently in place, and 135,000 lifetime mortgages (providing equity release).[10]

The long term care market – overview



[3] Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008
[4] Laing and Buisson, *Care of Elderly People Market Survey 2007*
[5] Wanless, D, *Securing good care for older people: taking a long-term view*, King's Fund, 2006
[6] Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008
[7] Ibid
[8] Carers UK, based on 2000 General Household survey figures, 2005
[9] Age Concern, *The Age Agenda 2008: Public policy and older people*, February 2008
[10] Laing and Buisson, *Care of Elderly People Market Survey 2007*. and Council of Mortgage Lenders *Please release me! A review of the equity release market in the UK, its potential and consumer expectations 2008*

Assessment of the market:

The efficiency of long-term care can be assessed by establishing whether:

1. Demand for care is met by supply, and care providers can respond to changes in demand.
2. Providers of care can make acceptable returns to encourage new investment and maintain operations.
3. Providers can enter and exit the market without too much difficulty and based on their profitability.
4. The market is not distorted to favour one particular purchaser of care.
5. Consumers can make informed choices based on readily available information.

Deloitte has concluded that whilst providers of care usually make acceptable returns and do not face insurmountable obstacles to market entry (criteria 2 and 3), it is debateable as to whether supply meets demand in the current market or can respond to it effectively (criteria 1). This is because the full scale of unmet demand is obscured by reliance on informal care, where data is not available to show how many older people resort to informal care due to the inability of the formal market to meet their needs. Some estimations indicate there is already an existing proportion of unmet need in the current market, even taking informal care into account.[11] Providers of care may not be able to respond to consumer demand, as this is often obscured by local authority commissioning decisions and the application of eligibility criteria. As such, supply is often limited to residential or domiciliary services with few alternatives catering to needs which fall between the two ends of this spectrum.

Deloitte also found that the current market may often be distorted to favour one purchaser (criteria 4). Local authorities are usually the single largest purchaser in a given locality, with the ability to set fee levels which may put pressure on supplier returns. As a result, care providers may often cross-subsidise and pass the costs of local authority under-funding on to self funders.

Finally, Deloitte concluded that the information asymmetry is particularly large in long-term care (criteria 5). This is due to an extremely complex system of eligibility rules for care services and benefits, combined with a shortage of information and advice services. Consumers are in an extremely weak position and cannot make informed choices about their care or access services they may be entitled to.

The fairness of long-term care can be assessed by establishing whether:

1. A single set of rules is applied to all.
2. Everyone can access services they need without financial hardship.
3. People can reasonably expect to "get something back".

Deloitte concluded that a general "rule of law" (i.e. that everyone is subject to the same set of rules) does not often apply in long-term care (criteria 1). Self funders and local authority funded older people with identical needs are treated differently, by being charged different amounts in care homes, and having different access to information, advice and assessments. Older people with identical needs and levels of wealth may or may not be eligible for state funded care, depending on where they live and on the case by case interpretation of front line staff.

They also concluded that a growing proportion of older people cannot afford the care they need without financial hardship (criteria 2). This is because needs-based eligibility is generally becoming tighter - meaning even those older people with very low wealth levels will not receive state supported care unless they also have very high care needs. As such, a growing proportion of older people are having to privately fund relatively expensive care packages to meet more intensive or complex needs (which nonetheless were not deemed high enough to warrant state funded care). This makes care less affordable overall.

In a re-distributive and progressive society, individuals' contributions to the state may not be in proportion to what they receive. However, a fair assumption is that people who contribute as citizens all of their lives will receive "something" from the state in their old age if they are in need (which may or may not include financial help). Deloitte judged that a decreasing number of older people receive "something" back from the state, even when in need (criteria 3). This was due to tightening needs-eligibility criteria, as well as variable treatment of self-funders which meant those with no financial support from the state often were given no other forms of support (e.g. guidance on how to buy their care privately).

Market developments:

Deloitte chose four key developments that are likely to affect the way in which the market currently operates, and suggested some likely outcomes. There are, of course, many other potential developments and trends that may offset or reinforce the impacts of the market developments described here. However, these four demonstrate the transitory nature of the current market and its sensitivity to future social, political, economic and demographic trends.

[11] See Julien Forder's modelling on behalf of CSCI in *The State of Social Care in England 2006-07*, January 2008

Market development one: the population ages according to demographic predictions

Analysis from the PSSRU and others, based on statistics from the Government Actuarial Department, suggests a large increase in older people and those with complex care needs.

- This trend will see an increase in the costs of care, one estimate suggests a 325 per cent increase in real terms will be required by 2041. This is because 1) there will be larger numbers of older people to cater for, a proportion of which will be eligible for state funded care; and 2) people living longer may mean people will require care for a longer period. However, it is debated as to whether increased longevity may also lead to compressed morbidity (i.e. people living healthier for longer).
- Increased rationing at local level would be expected to attempt to keep costs down, however further needs-based tightening towards "very critical" needs could increase the burden on the NHS.

Market development two: funding increases remain broadly constant

Assuming the existing 1 per cent funding increase over the next three years did not significantly increase, Deloitte expected resource shortages at local level would become more apparent against predicted growth in demand:

- Local authorities would continue their rational response to funding shortages - focusing their limited funding on those with the greatest need by tightening eligibility criteria for state funded care; and trying to make their funding "go further" by setting low fee levels with care suppliers.
- Local authorities risk creating a vicious circle of inefficient spending - as remedial care is more expensive than preventative care, local authorities will find they spend more overall by focusing more tightly on the most critical needs, thereby reducing the budgets yet further. A lack of preventative care may also increase costs to the NHS.
- By rationing care to fewer numbers of people, the numbers of self funders in a given location may rise. This could see some local authorities lose their dominant market position and undermine their ability to set low fees with care suppliers, which may lead to further cost pressures.

Market development three: the introduction of personal budgets

Deloitte concluded personal budgets, being rolled out from April 2008, would affect the long-term care market in a number of ways:

- It would disaggregate demand - leading to an increase in transaction costs for suppliers, and potentially more market entries and exits in the short term as suppliers react to a greater range of demands being expressed by personal budget holders.
- Information and advice would become more crucial as more people make their own care decisions. The current lack of advice would have more serious consequences if left unchecked.
- Overall, personal budgets would allow supply to respond more effectively to demand than is currently the case, and may lead to local authority- and self-funded older poeple being treated more equally by suppliers.

Market development four: technological advancement changes the nature of care

Telecare packages are becoming more advanced and could transform the way people live independently in their home.

- Telecare can reduce the costs of care overall, by creating affordable preventative services and low level monitoring. This may reduce the cost pressures created by targeting resources on remedial care only, and help offset the increase in demand associated with demographic change (see above).
- Telecare could be a valuable supplement and in some cases replacement of domiciliary services, which will have an impact on the sector and the workforce.
- Slow roll out of third generation telecare technology suggests this will be an evolutionary process.

Conclusions and next steps

Based on their analysis of fairness and efficiency, Deloitte concluded there were five key areas of weakness in the current market:

1. Informal care
   - The formal care market relies on informal relationships (family and friends) to supply a considerable amount of care for free to older people. Such reliance reduces the costs to the state and also meets any shortfalls in care the formal care market may generate. Nevertheless, relying on informal care to such a degree is a high risk strategy, with hidden social costs. First, informal care relationships can be fragile, so consistency of care cannot be guaranteed. There is also no guarantee of the quality of informal care, so that a proportion of those currently relying on informal care may not be having their needs met (and storing up problems which the local authority or NHS may have to deal with in the future).

[12] http://www.pssru.ac.uk/pdf/rs035.pdf
[13] Ibid

- It should also be remembered that informal care is not "free" - the costs are borne by informal carers who may give up work (and reduce their own incomes) in order to fulfil their caring roles.[14] This can have a particularly significant impact on the financial well-being of lower earners.
- Demographic change may also render informal care a less viable alternative to formal care in the future. There will be an increase in the number of older people with complex care needs, for whom informal care may not be adequate. Also falling birth rates and potentially more mobile populations suggest fewer younger people will be available in the vicinity to care for their older relatives.

2. Navigation
   - There is a shortage of available information and advice in the current long-term care market, so older people and their families find it hard to make informed choices about their care and how to fund it.
   - In addition, the current system of eligibility and benefits is very complex and locally variable. This means that even with a comprehensive advice and information service available, people would still find it challenging to navigate the care market effectively. The interlinked yet distinct operation of social care and NHS care, one means tested, one free, and with separate delivery systems, also adds to the overall confusion.
3. Funding
   - Tight budgets in the long-term care market can generate inefficiency, for example, targeting limited resources on those with most critical and urgent need. This diverts funding from preventative services, which are more efficient and save money in the longer term. A lack of funding now is likely to lead to more money being spent overall, creating a vicious circle of funding shortages and inefficient spending.
   - Private resources are also being used inefficiently due to poor financial planning. Low take up of equity release products means few people are able to access the equity in their homes to pay for domiciliary care if they do not have sufficient liquid savings. Such people may be "fast tracked" into residential care as the only viable alternative for those with higher level needs. A lack of available private resources may be one reason why there are few alternatives to domiciliary and residential care currently being supplied in the market (though the growth of extra-care services suggests some supply is being stimulated in some areas).
4. Local markets
   - Much of the local variation in the care market is driven by local authorities' intermediation role. Variation in needs based eligibility can lead to geographical variation in access to care, funding available, and fees payable, and therefore variations in outcomes.
   - Local markets can also be dominated by a single purchaser more easily, and limits suppliers' ability to make economies of scale. Regional or sub-regional eligibility and purchasing may be more efficient.
   - Nevertheless, as a social good, the market cannot be left unregulated and local authorities have a crucial role in shaping the market. This needs to be done strategically by encouraging affordable supply of care in local areas to meet the needs of the entire older population.
5. Responsiveness of supply
   - Care suppliers can meet the volume of demand for formal care, but less effectively adapt to the types of care demanded. There are a number of potential explanations:
     i. Considerable reliance on informal care masks latent and unmet demand. Suppliers are unable to identify untapped and niche markets as demand is absorbed by informal care.
     ii. A lack of resources to spend by self funders dampens demand. For example, low take up of equity release means self funders are unable to access equity from their homes and stimulate alternatives to traditional domiciliary and residential care.
     iii. The relatively small number of self funders maintains the local authorities' position as the largest single purchaser of care. As such, suppliers are incentivised to respond to local authorities' commissioning decisions which, unless based on a thorough whole-population needs assessments, risks limiting the range of services made available in a local market.

A fair and efficient long-term care market

We have sought to describe how the market operates as a series of interdependent parts. As such, the individual weaknesses we identify based on the Deloitte analysis must be considered in the round: it is crucial that not one, or even a few, areas are targeted for reform in isolation from the whole - if this were to occur, then the "tweaking" at the edges may have knock-on effects which de-stabilise other parts of the market.

[14] A Carers Strategy is due to be published in May 2008. It is expected this will address issues of financial and other support available for informal carers

The Deloitte analysis demonstrates that there is scope for greater efficiency and fairness in the market within existing resource constraints. Nevertheless, this analysis and a wealth of other research does suggest that further resources will be needed to improve and expand the long-term care market in the future. It is important, however, that a reform programme and funding settlement work hand in hand. The current market needs to be made "investment ready" i.e., made to operate more efficiently so that it can make the most of new resources that may be forthcoming.

A final point that needs to be borne in mind is that the market developments identified by Deloitte illustrate just how transitory the conditions of the current long-term care market are. The market is vulnerable to multiple trends, political, economic and demographic, and only with a systemic reform can sustainable outcomes be achieved.

The Foundation believes that reform ought to be based on an overall vision of what an efficient and fair long-term care market ought to look like in the future. This vision would create a unifying outcome which individual reforms could work towards, providing greater consistency, and impart a "long term view". Such a vision could become an extremely powerful, multi-generational settlement if it were subject to political consensus, and received cross-party, third and private sector support.

What will the Foundation do next?

In the next six months, the Foundation will embark on 1) a consultation process with different groups of stakeholders to explore what a fair and efficient long-term care market ought to look like, and 2) a series of research projects exploring in more depth and developing potential solutions to some of the key areas of weakness identified above. These two streams of work should enable us to construct a coherent vision of a long-term care market, which is fair, efficient, and can withstand future developments.

We will continue to develop this analysis and build a coherent picture of the long-term care market, focusing particularly on low earners and how their position can be relatively improved through future reform. We will report back to all interested parties and publish our findings by the end of 2008.

Section One: Introduction

What is the Resolution Foundation?

The Resolution Foundation is an independent research and policy organisation established in 2005. Our goal is to improve the wellbeing of low earners[15] in today's mixed economy. We aim to deliver change in areas where this income group is currently disadvantaged by producing new research and actively engaging in the policy-making process.

Our first project

Out first research project was to explore how low earners access financial advice, and how any obstacles to this access could be overcome.

We carried out and commissioned a number of pieces of original research, economic modelling and analysis, exploring costed solutions for a national advice service. In January 2007 the Treasury announced an independent review into the provision of generic financial advice led by Otto Thoresen, the Chief Executive of Aegon UK. Their final report, published in March 2008, recommended a new national Money Guidance service, which drew from the Resolution's own work. The Government endorsed this report and, with the FSA, committed £12 million to a regional path finder to test a new service.[16]

The Foundation's approach is to target our resources on one major development project at a time. Therefore, whilst we will be engaging in the continuing work on the Money Guidance pathfinder and the financial capability debate more widely, our focus since January 2008 has been to develop our thinking on the issue of long-term care for older people.

Why did we choose to look at long-term care for older people?

The Foundation works on a project basis, actively lobbying to ensure that our work delivers outcomes. As such, we had to make sure we moved forward into an area of policy which materially affected low earners within the context of a mixed market, but also where we might add value and could achieve change with our approach of developing pragmatic recommendations, based on robust evidence and economic analysis. We felt long-term care met these criteria:

1. *There is evidence of need for reform and a window of opportunity to influence the reform process*

Demographic change means that the numbers of older people requiring care will increase significantly over the next decade. However, the resources available to fund this care are limited. As such, there is growing political appetite to resolve some of the policy problems that exist. The Government gave a clear signal that it planned to tackle the problem in the 2007 Pre-Budget Report and Spending Review, which announced a Green Paper on Adult Social Care for 2008. Outlines for a broad reform programme for 2008-09 have developed since this announcement: In December 2007 the Department of Health published a ministerial concordat. This document claimed "*there is now*

[15] We define this group as those individuals who earn less than median incomes but who are receive less than 20 per cent of their incomes from state benefits. Households earning between around £14k and £23k and individuals between around £7,300 and £12k would fall into this group.
[16] See *Thoresen Review of Generic Financial Advice: Final Report*, March 2008

an urgent need to begin the development of a new adult care system."[17] It went on to outline a multi-departmental commitment to a raft of ambitious reforms, many of which may be expected to be developed in the Green Paper. These Included a focus on joint working at a local level to bring together housing, transport, social services, health and community wellbeing; a preventative approach to social care interventions; personalisation through the roll out of personal budgets; and the universal provision of advice and guidance to allow older people and their families to navigate the long-term care system more easily.[18]

In January 2008, the Government also responded to the Commission for Social Care Inspection (CSCI)'s *State of Social Care* annual report by announcing an investigation into the way in which eligibility criteria for subsidised care was operating at local level and the unintended consequences this might be having.[19] A public consultation on a new funding regime was also announced, to report back to Government in the Autumn of 2008. In February 2008 the DCLG launched the *Lifetime Homes, Lifetime Neighbourhoods*, housing strategy, which among other things provides more funding for home adaptions for older people and outlines a strategy to build homes suitable for people to grow old in.[20] On 1st April 2008, a three year Transformation Programme began, using £520 million of ring fenced funding to roll out a number of reforms, including facilitating the use of personal budgets by the majority of older people using care services.[21] In May 2008, a Carers Strategy is also planned, which is expected to outline a new support package for those who give up work to look after an older relative.

In spite of this ambitious start, the October 2007 Comprehensive Spending Review (CSR) only heralded an increase in funding for local authorities to provide adult social services of £2.6 billion by 2010-11, a real terms annual increase of 1 per cent a year. The Local Government Association (LGA) described it as 'the worst funding settlement for a decade'.[22] Warning that local authorities will be forced to raise Council Tax and implement further cuts in services, it described the current care system as 'creaking at the seams'. As such, there remain questions regarding the resources that will be made available to deliver the level of change indicated by recent policy announcements. The Foundation believes that embarking on a significant programme of research to improve the efficiency and fairness of the current system in a strategic manner will be both timely and extremely valuable to the Government, policy makers and third sector stakeholders in the forthcoming year.

2. *Long-term care functions as a mixed market of funding and provision*

The Foundation is particularly interested in how low earners fare in the mixed economy. Long-term care very much demonstrates the qualities of a mixed market, a concept we explain in the next section. In short, long-term care for older people is funded by a combination of private contributions and government funding, and delivered by a mixture of private, local authority and third sector organisations.

3. *It is an area which directly impacts on the lives of low earners*

Long-term care for older people presents particular challenges for low earners, for a number of reasons:

- Low earners are more likely to be 55+. This is both the peak age for becoming a carer of an older relative, as well as a time when individuals may be considering their own care needs.[23]
- Low earners are more likely than average to be carers as well as care users (a survey commissioned by the Foundation found low earners were twice as likely to be care users and 25 per cent more likely to be a carer).[24]
- Low earners are on the "cusp" of means testing eligibility. This means they are often assessed as too wealthy to be eligible for state subsidised care, yet their relatively low incomes make care costs a much more significant financial burden than for higher earning self funders. Low earning recipients of care, and their families, are therefore likely to see a larger proportion of their weekly budgets spent on care costs than both higher and lower income groups.
- As self funders, low earners will also face the same difficulties as other self funders face, including a lack of information and advice, and potentially higher fees for the same services.[25]

The Foundation's previous research, a qualitative study exploring low earners' opinions and experiences of long-term care, illustrated how they felt unfairly treated by the care system and confused and frustrated by its complexity.

*Lost: Low earners and the long-term care marke*t presented a range of findings from focus groups and depth interviews with low earners commissioned by the Foundation, as well as a YouGov Survey of UK adults from a range of income groups. Key messages regarding the quality and affordability of care included:

[17] Department of Health: *Putting people first: a shared vision and commitment to the transformation of adult social care* 2008
[18] Ibid
[19] http://www.communitycare.co.uk/Articles/2008/01/29/107088/ivan-lewis-orders-adult-care-eligibility-review.html
[20] http://www.communities.gov.uk/housing/housingmanagementcare/housingolder/
[21] http://nds.coi.gov.uk/Content/Detail.asp?ReleaseID=337211&NewsAreaID=2
[22] http://www.guardian.co.uk/business/2007/oct/10/politics.economicpolicy
[23] Resolution Foundation *Living in the Advice Gap*, 2006
[24] Resolution Foundation, *Lost: low earners and the elderly care market*, 2008
[25] We explain this in more detail below.

- People are not satisfied with long-term care and a majority feel the service is deteriorating in both affordability and quality.
- There is a strong consensus that something needs to be done to change the current system, with only 4 per cent wanting to keep the system as it is.
- Between 71 and 74 per cent thought reform ought to be a policy priority equal to higher profile NHS reforms such as extending GP opening hours.
- People are strongly in favour for care to be provided to the majority for free, and 71 per cent (75 per cent of low earners) stated they would be willing to pay extra income tax to secure this outcome.
- There was low awareness, but wide disapproval of the current means testing rules. Nearly half felt people's homes should not be included in means testing calculations, whilst another 15 per cent thought houses only worth more than £500k should be taken into account.
- 60 per cent of those surveyed reported not knowing where to access, or not having been able to access, the information they needed to plan their or their relatives' care needs.
- 73 per cent thought the means testing income threshold of £21.5k should be substantially increased.
- 45 per cent of low earners stated that they had no provision for their care needs, and were unsure how they would fund them, compared to 38 per cent on average.[26]

Our survey also found that low earners most often expect to be wholly funded by the government, and least often think they will have to pay for all of their own care needs. This is in line with their belief, expressed in various ways in focus groups and interviews, that those who contribute to the state through national insurance and income tax, for example, should receive care when they need it, in a "fair contract" with the welfare state. As a group who are mostly working poor (i.e. are on low incomes, but are employed and are not dependent on welfare benefits), it is understandable that this group would consider themselves deserving of subsidised care.

However, this illustrates a significant disparity between this group's expectations and reality - around 70 per cent of low earners are likely to have assets over 21.5k by the time they are 65, which, subject to the exclusions written in to means testing eligibility rules, means they may have to pay for all of their care. Yet over half believe they will have their care totally or mainly funded by the government - almost the same proportion as lower earning individuals.[27]

It is hardly surprising, then, that the key theme that arose in all of the focus groups and interviews was the lack of "fairness". This was taken to mean, variously, people not receiving what they deserve (i.e. in return for their contributions to the state during a working lifetime) - particularly when compared with those seen as less deserving (i.e. those who had not worked and saved all of their lives) often receiving free care; people having their homes included in means testing eligibility criteria and having to sell their homes to fund residential care; people receiving more or less from the state depending on where they live; and people having to "fight" for information and to gain access to what they are entitled to in benefits and care - suggesting the persistent, vociferous or better informed may receive more from the state than others.[28] Low earners' strong sense of "fairness" in relation to long-term care has helped inform our assessment in the following section.

What is our approach to long-term Care?

Based on our own research and a consultation process with several stakeholders and experts in the third sector, government and the private sector, we were struck by the sheer scale and complexity of the delivery mechanisms behind long-term care, as well as the significant amount of existing research and policy development that had already taken place. This had had a number of consequences - the first being that much reform and development had come about in a piece-meal fashion, and often addressed a single problem in isolation of the whole. A second consequence was that long-term care risked becoming too large, unwieldy and fragmented for anyone to tackle without causing significant (if temporary) disruption and hardship to those currently relying on the system for their care. Third, it has become very challenging to "see" the system as a whole and understand its interacting parts, rather than a collection of problems.

One way of encapsulating long-term care in a holistic way, and enable a systematic assessment of its weaknesses, was to draw together the existing body of research and data in this field and apply a conceptual framework.

In the next section of this report, we explore the issue of long-term care through this framework, which is based on the understanding that according to its most basic functions, *long-term care operates as a market*. As we explain in the following section, the long-term care market is driven by supply and demand, based on transactions delivering a service at set prices.[29] Approaching long-term care in this way has a number of benefits: it becomes

[26] Ibid
[27] Ibid
[28] Ibid
[29] Although these prices are subject to considerable local variation, as we explain below.

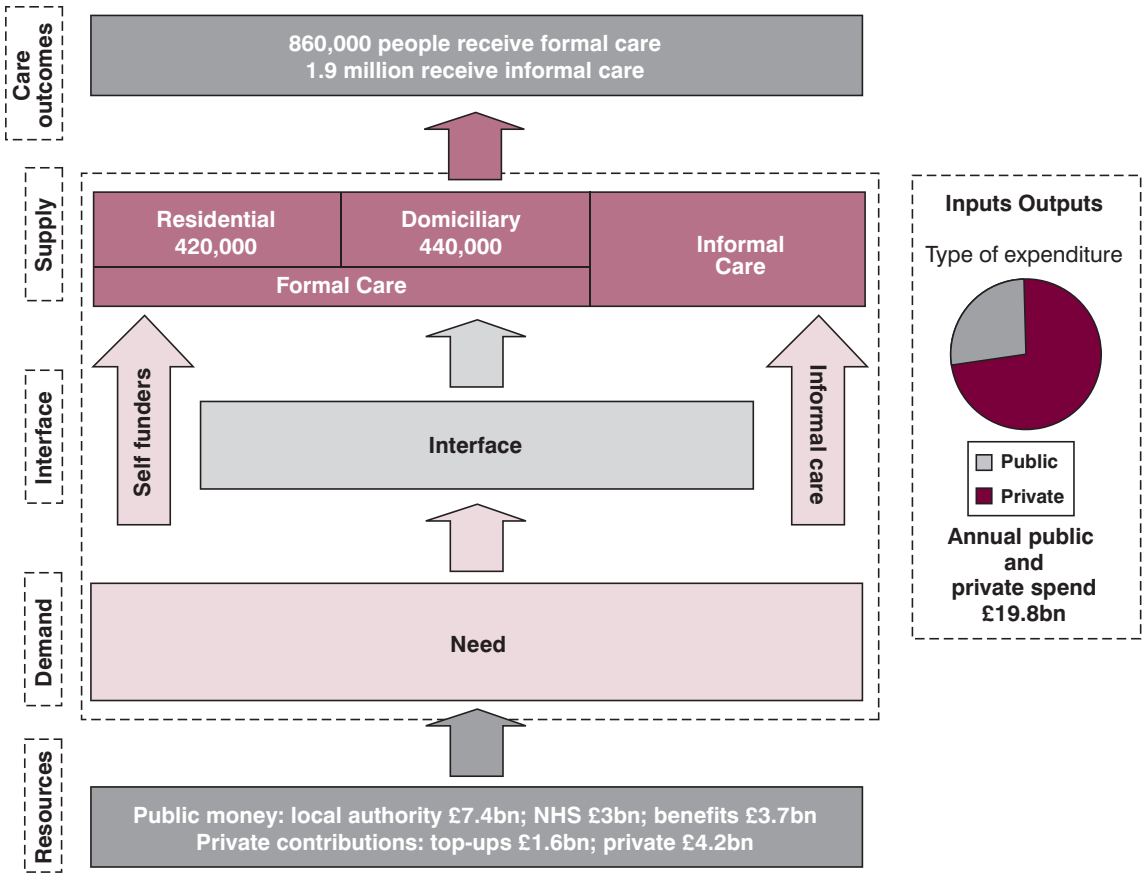
easier to consider this extremely complex network of services and agencies at a macro level, by quantifying and describing levels of supply and demand and the interaction between the two. This "market map", carried out by Deloitte for the Foundation, is presented in the following section. A second benefit is that we can apply a set of criteria, based on existing market theory, to assess how well the current long-term care market is functioning - at its most basic, does supply meet demand? Is there transparency of price and quality? These, and other measures of efficiency, are applied in the following analysis carried out by Deloitte.

However, long-term care is by no means a typical "private" market - where consumers use their own resources to purchase a simple private good, like a television. Instead, the long-term care market deals with the provision of a "social" good - care for older people. As a social good, the government has a responsibility to ensure that those in need of care, but who cannot afford it, receive it through the state. As such, we cannot assess the long-term care market purely on efficiency grounds - we also have to consider how progressive and re-distributive it is in ensuring those in need can get the care they require, regardless of their ability to pay. Our previous research demonstrated just how important "fairness" was as a concept when discussing long-term care. Deloitte therefore carries out an assessment of the overall "fairness" of the market, alongside an assessment of its efficiency.

What do we mean by "long-term care"?

Long-term care can be a broad term to cover a number of services which enable older people to enjoy a better quality of life. This can include a range of day services provided in community centres as well as leisure services and those jointly delivered with the NHS. However, Deloitte's "map" of the long-term care market and assessment of its efficiency and fairness focuses on the two principle forms of formal long-term care provision - residential care, and domiciliary care. It also takes into account the large role informal care has to play in the delivery of care for those, through choice or circumstance, find themselves excluded from the formal care market. The diagram below gives estimated figures of the value of this market:[30]

The long term care market – top line resources and care outcomes[31]



[30] Sources for these statistics are variously: Wanless, D, *Securing good care for older people: taking a long-term view*, King's Fund, 2006; Carers UK, based on 2000 General Household survey figures, 2005; Laing and Buisson, *Care of Elderly People Market Survey 2007*; and Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008

[31] We have used the Wanless Review's 2005 figure of 3.7bn a year being paid to individuals in Attendance Allowance and Disabled Living Allowance in the figure referred to here as "benefits". Of course, this may be used to purchase formal care, informal care, or indeed no care related services at all.

Section Two: Mapping the market of long-term care

We can demonstrate how long-term care functions as a market by reviewing its defining characteristics:

Characteristics of long-term care:

There is defined demand for care:

- Demand for long-term care is represented by need. Based on analysis of ADLs[32] by the PSSRU, 2.447 million older people have some form of personal or nursing care need and could be described as the potential demand for long-term care.[33]
- Within the existing market, demand for all services has been steady in the last 10 years, with occupancy in care homes over 90 per cent during the last five years.[34]
- Demand is expected to increase as a result of demographic trends. Whilst much may be absorbed by informal care, a growing proportion of older people will have levels of need which can only be met by the formal sector.

There is an established supply of formal care serving current demand:

- The residential and domiciliary supply sectors are worth around £19.8bn and deliver care to around 860,000 older people.[35]
- Levels of supply and prices are subject to considerable local variation.
- Supply will need to grow in the near future in order to meet a growth in complex care needs driven by demographic change.

A transaction takes place:

- An individual or their intermediary (usually the local authority) buys care services from a supplier.
- This transaction may not be a fully informed one, and may have certain restrictions placed on it by the local authority.

Price is sensitive to demand:

- Suppliers of care set their prices based on what purchasers are willing to pay.
- Through their position as the single largest purchaser, local authorities can negotiate prices with suppliers.
- Basic costs are influenced by the requirement to meet minimum legal standards.

What type of market is it?

As explained in the introduction of this report, the market of long-term care is mixed - in both funding and supply. The combination of public and private funding used to purchase care is a result of care being a "social" good, namely, one which the state has a responsibility to buy on behalf of those who need it but cannot afford it themselves. Long-term care can therefore be seen as a "social" market.

Another defining feature of the long-term care market is that is it extremely localised. In fact, it can be seen as a diverse collection of local markets, each with its own supply and demand characteristics. As such, the potential local variation in the top-line data needs to be borne in mind.

Examples of local variation:

- Torbay has 74.6 care home places per 1000 of population over 65 compared to 12.1 places in Westminster[36]
- In 2007 there was a 44 per cent variance in residential fees: people in the 'Northern Home Counties' paid on average £165 more per week for their care then people in Wales. For nursing care, individuals in the Northern Home Counties paid £815 per week on average - £298 or 58 per cent more than people in Northern Ireland, who paid £517 per week on average.[37]
- Vacancy rates of social service staff vary from 11.8 per cent in outer London to 6.8 per cent in the South West.[38]
- The Isle of Wight does not means test for home care, and delivers it free, to all those over 80.[39]

The key elements of the market: demand, supply, and intermediation

The diagram opposite quantifies the demand, supply and subsequent shortfall in care in the existing formal care market. As we can see, potential demand is taken to be the number of older people estimated to have some personal or nursing care needs based on their ability to complete activities of daily living (ADLs) such as washing and dressing. Higher need is measured as not being able to complete one or more ADL. Those deemed as having "lower need" cannot complete one of more "instrumental" ADL for themselves - such as shopping, cleaning, or managing personal affairs (e.g. paying bills).

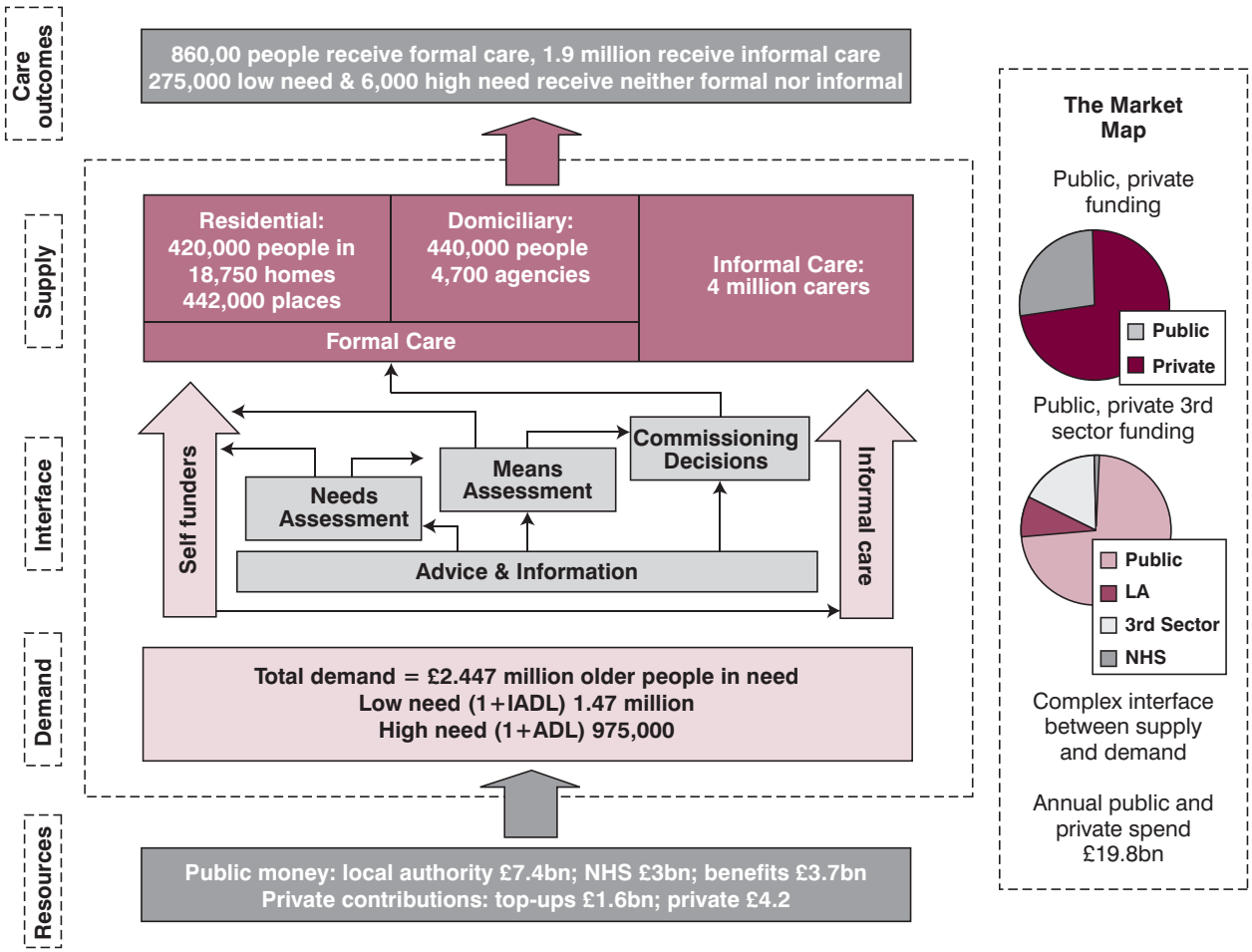
[32] Activities of Daily Living
[33] Wanless, D, *Securing good care for older people: taking a long-term view*, King's Fund, 2006
[34] Laing and Buisson, *Care of Elderly People Market Survey 2007*
[35] Ibid
[36] Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008
[37] Laing and Buisson, *Care of Elderly People Market Survey 2007*
[38] Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008
[39] http://www.iwight.com/home/news/budget07/freehomecare.asp

Between supply and demand is an area of activities, processes and agencies we call "intermediation". In most private markets, supply reacts to demand by the actions of consumers - e.g. their decisions to purchase a product according to price or quality. In long-term care, supply and demand interact in a less direct way, often through local authorities as an intermediary for purchasing state funded care on behalf of older people. However the third sector (in providing advice and brokerage) and national government (in setting means testing benchmarks) also have a role to play in this "intermediary" area, which influences the relationship between supply and demand.

The shortfall between supply (of formal care) and demand (need for care) is around 1.6 million people. These people often do not seek formal care, preferring to rely on informal care from friends or family. Nevertheless, a proportion are those who may have been deemed ineligible for state funded care, but who feel they cannot afford to pay for care privately may also use informal care as a fall back option. Therefore, either by choice or circumstance, around 65 per cent of older people with potential care needs are not served by the formal care market.

To estimate levels of shortfall in formal care, we can use statistics from CSCI's recent analysis: Around half of those who do receive formal care also receive informal care, suggesting this is used to supplement the shortfall in their formal care package. Modelling also suggests that around 450,000 people receiving formal care were experiencing a shortfall in their care even though they also used informal carers, and also found 6,000 people with high needs and 275,000 people with low needs were not receiving either formal nor informal care.[40]

The long term care market – overview[41]



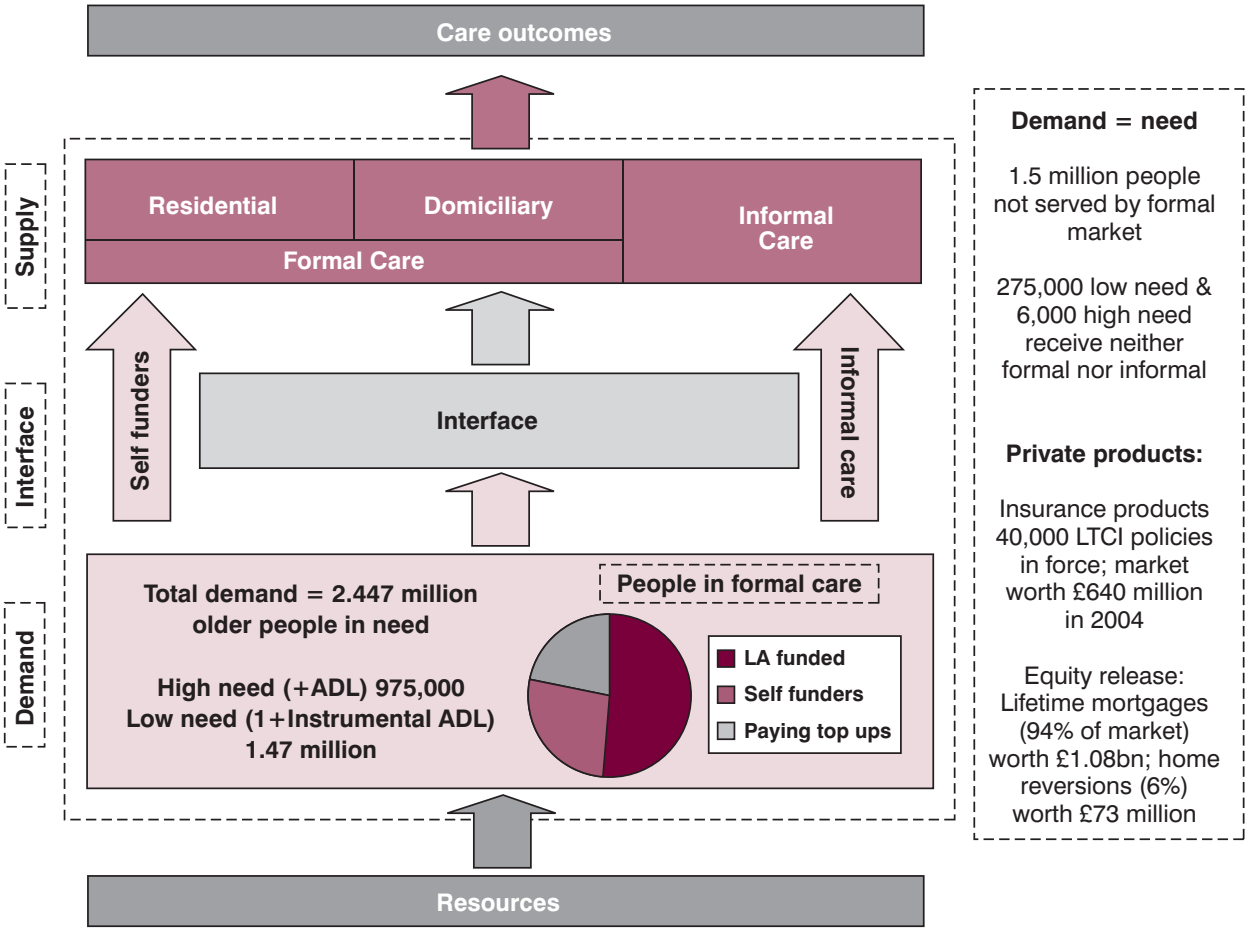
[40] Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008

[41] Sources for these statistics are variously: Wanless, D, *Securing good care for older people: taking a long-term view*, King's Fund, 2006; Carers UK, based on 2000 General Household survey figures, 2005; Laing and Buisson, *Care of Elderly People Market Survey 2007*; and Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008

The market in more detail

Demand:

Mapping demand[42]



As we explain above, need is the principle driver of demand for long-term care. Nevertheless, the ability to pay for this care also plays a part for all older people assessed as ineligible for state funded care and who have to pay part or all of their care costs themselves. State funded older people tend to be those with the highest needs and lowest incomes (only those with less than £13k in assets receive wholly state funded care, but even then may be subject to one-off charges for particular services). Given the potentially high costs of care (nursing home fees can reach £800-900 per week,[43] while home care can cost £17.50 an hour)[44], the local authorities' decision whether to subsidise an older person's care (based on eligibility assessments) can have a huge impact on what that person then receives from suppliers.

The numbers of people in residential and domiciliary care, by source of funding[45]

Souce of funding	Residential	Domiciliary
Local Authority Only	200,000 people £4.6bn p/a	309,000 people £1.85bn p/a
Private Funds Only	118,000 people £2.3bn p/a	150,000 people £697m p/a
Private Top Up	70,000 people £1.38bn p/a	150,000 people £600m p/a

[42] Ibid
[43] Laing and Buisson, *Care of Elderly People Market Survey 2007*
[44] http://www.communitycare.co.uk/Articles/2007/04/19/104203/domiciliary-care-charges-why-the-variations.html
[45] Figures sourced from Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008

For those who self-fund all of their care (i.e. those assessed as having lower care needs and, subject to some caveats, those with more than £21.5k in assets[46]), choice is limited by the money they have available to spend, and availability of local supply. Whilst the latter may be beyond the control of individual consumers, the former is extremely important: few people have adequate liquid savings to cover care costs, which, in a residential nursing home, can run to £800-£900 per week. In the absence of large savings, there are two main types of financial product which can help pay for care, but their take-up is very low.

Long-term care insurance - this spreads the risks of having to pay for care costs, so more people pay, but a lower amount.

However: only around 40,000 policies are currently in place, in spite of the fact that people have a more than 1 in 4 chance of requiring care in later life.[47]

Equity release - this allows people to use part of the equity in their homes without selling it. This works very well for those who want to remain in their homes and buy home care privately, or fund a residential care stay without having to sell up.

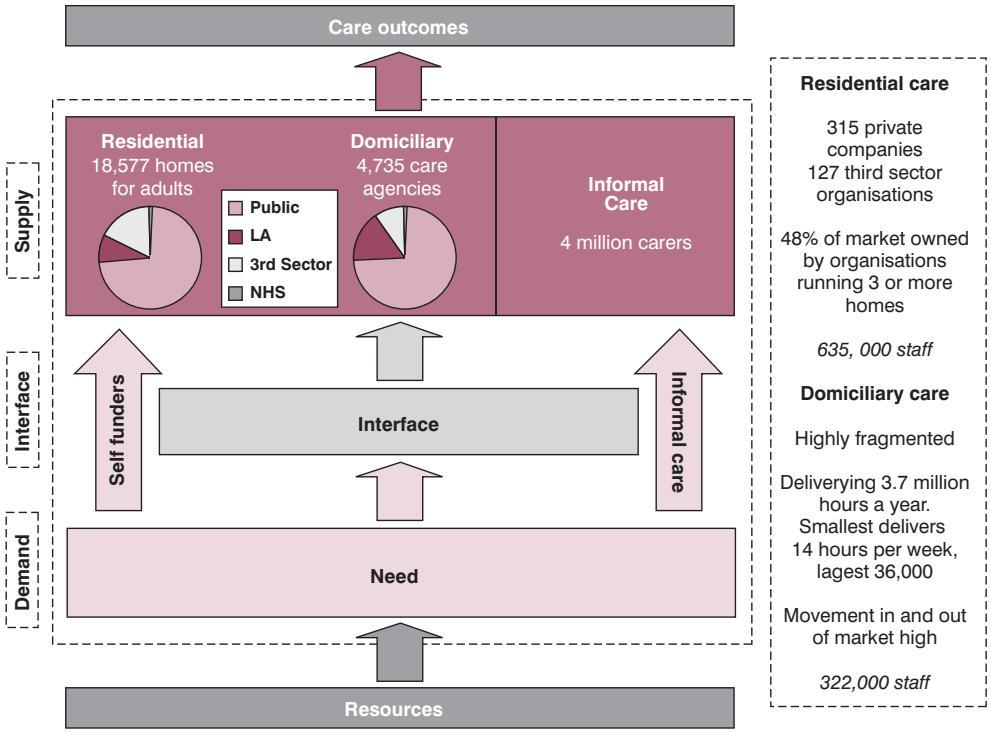
However: only 135,000 life time mortgages are in place, worth £1.08bn, which makes up 94 per cent of the equity release market. This is in spite of the fact that people over 65 currently have £500bn in un-mortgaged equity.[48/49]

A note on other products: there are other options available to older people seeking to pay for their care without selling their homes. One such option is known as a "deferred payments scheme". These schemes, offered by local authorities, allow older people to defer paying for their care until after they have died. The amount owing (plus interest) in fees is taken from the older person's estate, allowing the older person to keep their home during their lifetime. Little information exists regarding the take up of such schemes, but public awareness seems to be very low.

A large proportion of demand is met via informal care. Currently, informal care accounts for 65 per cent of the care delivered in the UK to people over 65. Of the other 35 per cent covered by the formal market, 25 per cent is funded by local authorities, and 10 per cent by individuals' private contributions.[50] The reliance on informal care can mask the potential demand in the market for formal services, making it hard for suppliers to identify niche markets and new opportunities.

Supply:

Mapping supply[51]



[46] Local authorities set their needs based eligibility criteria themselves, though around three quarters of local authorities only provide funded care to those assessed as having critical or substantial need. Once a needs assessment has been carried out, and a person found to have high enough need to be eligible, a means test is undertaken. These guidelines, set nationally, state that those with more than £21.5k in assets and davings are not eligible for any free care. If an older person is seeking residential care, then the value of their home is taken into this calculation of assets

[47] Statistics kindly provided by the ABI, 16 April 2008

[48] Council of Mortgage Lenders *Please release me! A review of the equity release market in the UK, its potential and consumer expectations* 2008

[49] The Joseph Rowntree Foundation's 2006 report, *Overcoming obstacles to equity release*, provides a valuable insight as to why older and lower income people do not take advantage of equity release. JRF are currently considering the possibility of equity release pilots to explore potential solutions to this problem.

[50] Age Concern, *The Age Agenda 2008: Public policy and older people*, February 2008

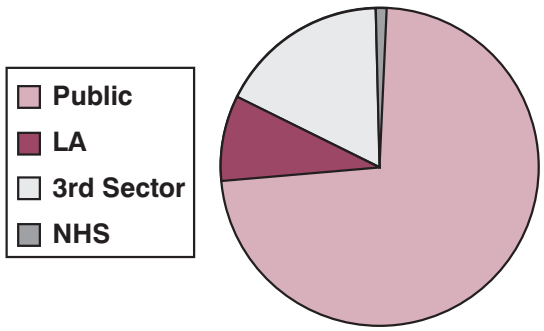
[51] Sources for these statistics are variously: Wanless, D, *Securing good care for older people: taking a long-term view*, King's Fund, 2006; Carers UK, based on 2000 General Household survey figures, 2005; Laing and Buisson, *Care of Elderly People Market Survey 2007*; and Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008

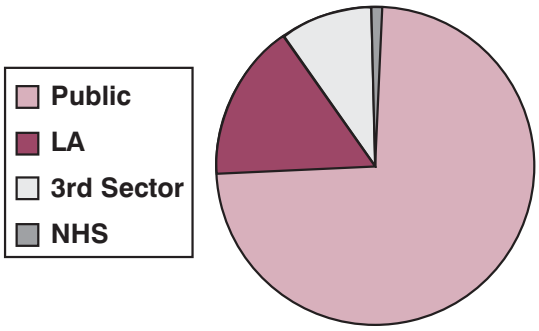
The supply of care can be described by the number of organisations providing care (i.e. care homes and domiciliary agencies); the volume of care delivered (i.e. the number of care home beds available and the number of hours of care provided by domiciliary agencies); or by the number of staff delivering care (i.e. the care workforce). By looking at these together, we can gain an insight into the nature of the domiciliary and residential sectors.

The diagram below describes the number of organisations delivering formal care, the number of places they offer/hours of care delivered and the balance of types of supplier in the residential and domiciliary care sectors.[52]

The numbers of organisations delivering residential and domiciliary care, by type:[53]

Residential	Domiciliary
18,577 homes for adults (441,000 places)	4,735 domiciliary care agencies (delivering 3.7 million hours per year)
13,400 private homes (344,000 places) 1206 council homes (31,000 places) 3437 3rd sector homes (59,000 places) 180 NHS homes (1,500 places) 315 private companies 127 3rd sector organisations	3,481 private agencies 719 council agencies 386 3rd sector agencies 47 NHS agencies
Care homes vary from 8 to 50 places average - 23.8 places per home	Agencies deliver 14 to 36,000 hours per week - 500 hours per week average



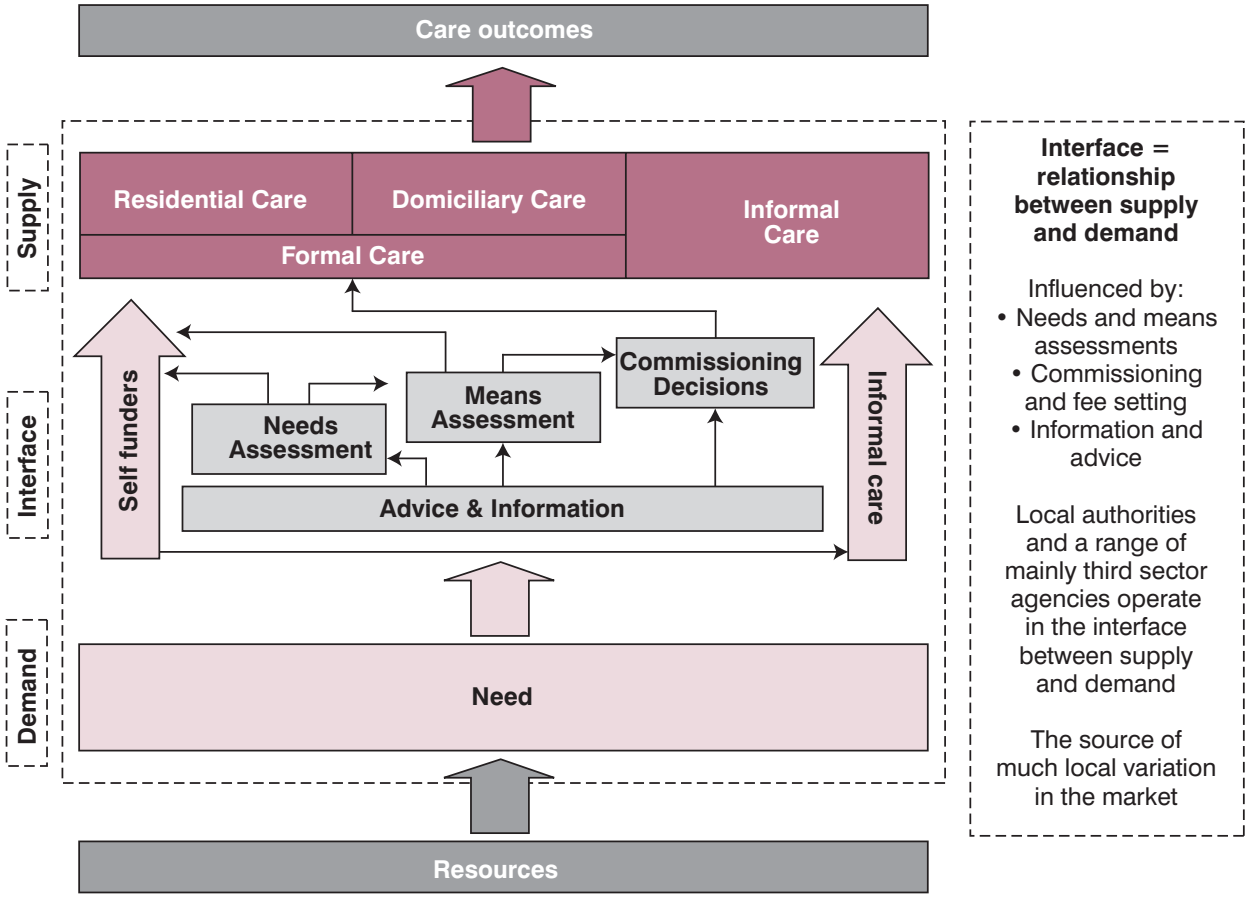


Based on the data above, is it clear that the market is mixed in terms of types of supplier, though dominated by the private sector. In addition, the size of the organisation delivering care varies considerably, particularly in the domiciliary sector. There are a large number of agencies operating, which is no doubt partly due to the fact that set up costs are relatively low (especially when compared to the capital requirements of a care home). This makes market entry fairly easy. Consequently, many agencies are also very small. This may make them vulnerable to fluctuations in demand or other external events, driving them from the market. Statistics tend to bear this out: CSCI reported 198 new entrants and 86 leavers to the domiciliary market in the year 2006-07 alone.[54] The residential sector is more consolidated, with the 8 largest care home suppliers having a 20 per cent share of the market and 48 per cent of the market owned by organisations running 3 or more homes.

[52] The statistics for the tables below are sources from Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008
[53] Sources for this diagram and tables are variously Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008 and Wanless, D, *Securing good care for older people: taking a long-term view*, King's Fund, 2006.
[54] The statistics for the tables below are sources from Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008

There are around 635,000 care staff employed in care homes, and 322,000 employed by domiciliary agencies. These figures are understandably dwarfed by the "informal workforce" delivering informal care to older people, which is estimated to be around 4 million. Within the formal workforce, it is estimated that 83 per cent are women and 50.4 per cent are part time workers.[56] Retention and recruitment is a recognised problem, with 100,000 vacancies for care workers advertised in the first 6 months of 2007 - this figure has remained above 75,000 since 2003.[57] Low pay, lack of training and low morale have all been blamed. This has an overall negative effect on care supply - high staff turnover increases transaction and training costs for suppliers and can undermine quality and consistency of care.

The interface between supply and demand[58]



As we explain above, demand and supply in the long-term care market does not often interact directly. A number of processes have an influence on the relationship between supply and demand, which form an interface between the two. Much of the local variation in the market is generated by these intermediary functions, which include:

Information, advice and brokerage services

Such services are often delivered by the third sector. The quality, depth, and independence of advice on offer is subject to substantial local variation. Given the complexity of care eligibility and funding rules, the provision of advice and information can have a huge impact on older people's ability to access the benefits and services they may already be entitled to, as well as helping them manage their finances in order to pay for care privately. Better information and advice could also help people generate and access private funds, which in turn could stimulate demand for more and different types of care.

[56] Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008
[57] Ibid
[58] See flow diagram below for more detail on the interaction between needs and means testing in this interface

Local authority commissioning care decisions

Local authorities choose which suppliers to award contracts to, and set how much they will pay per person eligible for state funded care. In care homes, fee levels can lead to cross-subsidisation, which increases how much self-funded residents have to pay for their care home places. Commissioning decisions also influence the choice of care locally available not only to state funded older people, but also to self funders (as many suppliers rely on block contracts with local authorities, those who are not commissioned by the local authority may exit the local market, thus removing a supplier for self-funded individuals to purchase from).

Setting needs and means eligibility criteria

Needs eligibility, set by local authorities, and means testing eligibility, set nationally (and, regarding domiciliary care, locally), both play extremely important gate keeping functions in rationing access to state-funded care. Where eligibility benchmarks are set directly correlates to how many older people are eligible for state funding, and therefore the volume of (state funded) demand.

Due to budgetary constraints, local authorities tend to be tightening their needs criteria so that only those with the highest (i.e. most urgent) need for care are eligible for state subsidy.[59] This, combined with means tested eligibility criteria, which is relatively low given current wealth levels of the over 65 cohort, generates a growing proportion of demand which is privately funded (though certainly a proportion of those deemed ineligible for state funded care will not turn to private funded care, but may turn to informal care instead).

Whilst means testing it set nationally, local authorities are only required to use this for residential care.[60] There is much room for interpretation regarding domiciliary care, as local authorities do not have to means test their care charges and have discretion to set charges themselves (subject to national guidelines that these charges must be "reasonable")[61]. Again, due to budgetary constraints, local authorities tend to be increasing their charges for domiciliary care, with the Isle of Wight an important exception:

Examples of local variations in domiciliary charging:

Since 1st April 2007, the Isle of Wight has been providing domiciliary care services free to all those over 80, regardless of income. As such, they have scrapped their means testing eligibility assessments.[62]

In comparison, and within the context of the average weekly home care charge rising 12.5 per cent in 2007,[63] Lambeth Council raised its hourly home care charge from £7.50 to £17.50 in 2007, whilst Cumbria Council increased the cost of home care as well as introduced means testing and a day care charge of £10 for a service that used to be free.[64]

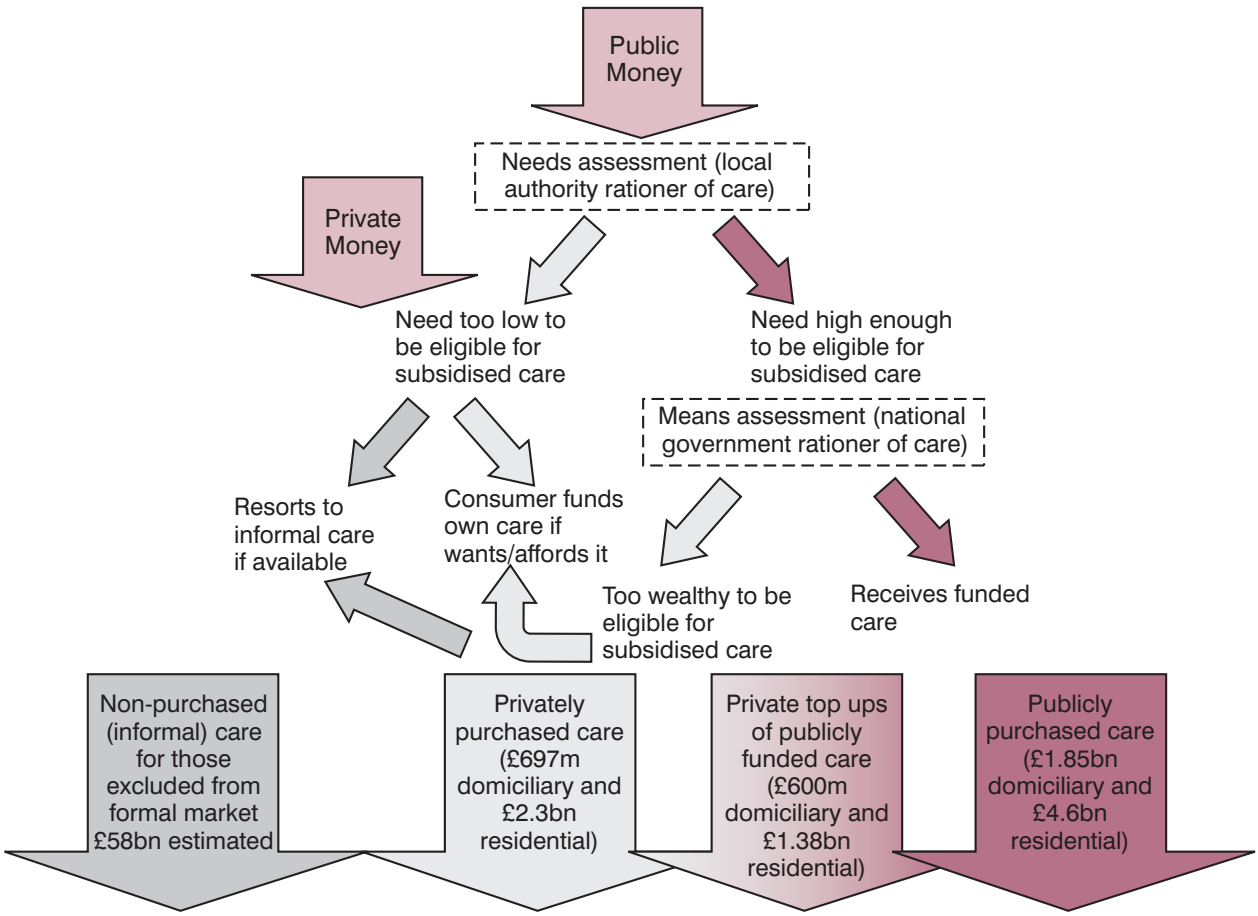
Therefore, local variation in demand, not just in terms of balance between state and privately funded but potentially also overall volumes, is mainly driven by needs-based eligibility benchmarks interacting with national means testing.

Needs and means assessments decisions

Applying needs and means-based eligibility criteria can be subject to local interpretation at the time of assessment. CSCI found variation within local authorities regarding the application of locally set needs criteria during the assessment process.[65] Variation in the interpretation of criteria can lead to very different outcomes for the older persons involved regarding their eligibility for state funded care and at what level - particularly those at the highest end of the needs spectrum who, through the interpretation of needs criteria, may or may not find themselves eligible for NHS continuing care (which is completely free of charge regardless of income) as opposed to high-level social care (which is means tested).

The following diagram illustrates how needs and means-eligibility criteria interact to signpost older people down different courses of action, significantly affecting the volume and nature of demand.[66]

[59] CSCI found that 73 per cent of local authorities would have their needs eligibility set at substantial or critical by the end of 2008, compared to 67 per cent the year before
[60] Though most local authorities who do charge for domiciliary care also means test, using the same national criteria as the means testing for residential care
[61] http://www.dh.gov.uk/en/SocialCare/Chargingandassessment/ChargingforSocialCare/DH_079535
[62] http://www.iwight.com/home/news/budget07/freehomecare.asp
[63] http://www.counselandcare.org.uk/assets/library/documents/21_Care_Charging_Survey_04.07.07.doc
[64] http://www.communitycare.co.uk/Articles/2007/04/19/104203/domiciliary-care-charges-why-the-variations.html
[65] Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008
[66] The statistics in this diagram are from Laing and Buisson, *Care of Elderly People Market Survey 2007*



Section Three: Assessing the market

Using the variety of data outlined above, Deloitte carried out an assessment of the current long-term care market based on two criteria: efficiency and fairness. Fairness refers to consumers (rather than suppliers or other agents) being treated fairly. These criteria were broken down thus:

In an efficient market:	Supply meets demand and responds to variation.
	Providers can make an acceptable return based on demand certainty.
	Market entry and exit based on profitability.
	The market is not distorted to favour one purchaser.
	Consumers can make informed choices based on accessible information.
In a fair market:	A single set of rules are applied to all.
	Everyone can buy services they need without financial hardship.
	People can reasonably expect to 'get someting back'.

Efficiency:

Supply meets demand and responds to variation

Suppliers of long-term care should be able to meet demand, in terms of volume, and be able to respond to changes in demand (i.e. consumer needs and preferences).

Deloitte concluded that this was only partially the case. This is because whilst top line data suggests there are sufficient care home places to meet demand (442,000 places for 420,000 people):

- There is little data available to assess whether the formal domiciliary care sector is meeting demand. Statistics do show care is being delivered to fewer households, and the amount of hours per household is increasing - reflecting many local authorities' focus on higher needs. In the last ten years, the numbers of households receiving home care fell by 120,000. It is likely that many households losing their home care services resorted to informal care, making this shortage hard to quantify.[67]
- Significant local variation renders the average national picture of 5 per cent spare capacity in care home places misleading. Westminster only provides 12 places per 1000 of the over 65s population compared to Torbay's 75.[68]
- A large proportion of demand is met informally by friends and family. This obscures how much formal supply actually does meet demand as shortfalls are "covered up". No data exists to indicate what proportion of the 1.9 million older people receiving informal care do so out of inability to access formal supply.

Also:

- Widespread use of informal care also makes it difficult for suppliers to identify changes in demand and respond accordingly.
- Eligibility rationing can distort consumer behaviour, also preventing suppliers from identifying and responding to changes in demand. Suppliers can usually only respond to local authority commissioning decisions.
- Supply responsiveness is also constrained by variation in geographical factors (for example property prices in London for care homes and overheads in rural and remote areas for domiciliary agencies).
- The market has not responded to latent demand for the spectrum of alternatives to residential and domiciliary care such as 'extra care', sheltered housing and assisted living. Whilst this sector is growing, it still remains a very small proportion of supply.
- Poor co-ordination between NHS and social services makes it difficult for providers to respond to demand and package home care services together.

Providers can make an acceptable return based on demand certainty

In a long-term care context, this criteria means that care homes and domiciliary agencies can make a margin of surplus, which can increase with increased demand. This both encourages new entrants into the market as well as investment, and allows existing suppliers to operate sustainably.

Deloitte concluded that this was usually the case, subject to local variation and a differing picture in the residential and domiciliary care sectors. Key factors included:

- According to analysis by Laing and Buisson, by 2006, residential care homes were making a profit of £6,750 to £9,800 per bed per annum. £8,500 per bed was calculated to be adequate to attract new investment.[69]
- The profitability of the seven largest care home operators ranged from 5 per cent to 27 per cent in 2006.[70]

However:

- Data regarding domiciliary agencies is not sufficient to assess whether returns are healthy in this market. The frequency of entry and exit in the market suggests returns may be low and/or unstable for some suppliers. Consumers' option of using informal care to replace domiciliary services is likely to keep prices relatively tighter than the residential care sector.
- Margins to cut costs and/or increase returns are limited:
  - Many local markets act as monopsonies, with the local authority placed in a powerful negotiating position regarding price. If a local authority sets the price it is willing to pay fairly low, this may keep supplier returns artificially low. Due to limited opportunities to reduce costs (see below), some care homes cross-subsidise self-funders' fees to make up for this shortfall.
  - Staff wages are the largest single cost for both domiciliary and residential care suppliers.[71] Wages are already low and the National Minimum Wage limits the scope to reduce the pay bill.
  - There are decreasing opportunities for property acquisition to aid growth. New development is held back by local authority fee levels and credit conditions.[72]

[67] Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008
[68] Ibid
[69] Laing and Buisson, *Care of Elderly People Market Survey 2007*
[70] Ibid
[71] Ibid
[72] Ibid

Market entry and exit is based on profitability

In long-term care, care homes and domiciliary agencies should enter the market based on the prospect of an acceptable return (though what is deemed acceptable obviously differs between public, third sector and private suppliers), and may be driven from the market if they operate at a loss.

Deloitte concluded that this was usually the case. Caveats included:

- In residential care, the building of care homes is not subsidised to make growth easier.[73] This limits opportunity for market entry in areas with high property prices, because the capital requirement becomes prohibitive. There are very few care homes in London, for example. In other counties, planning mechanisms create 'community services zones'[74] to help insulate care homes from property prices.

Example:

The two councils with the lowest number of care beds per 1000 of the over 65 population are Westminster (12.1 beds per 1000) and Kensington and Chelsea (16.4 beds).[75] These two areas have the most expensive residential property prices in the country.

Overall, inner London has 21.9 places per 1,000 older people; outer London, 38.9; and England 47.7.

As a result of this shortage, many London Boroughs commission care home places in other parts of the country for their older populations. Far more older people live in care homes outside their home borough in London than elsewhere: 49 per cent in inner London, 31 per cent in outer London, and just 14 per cent in England as a whole.[76]

- In domiciliary care, there are limited regulatory and market barriers to entry. This is likely to have helped generate the highly fragmented market of numerous small providers that exists. As such, entry and exit is relatively high and less based on an agency's operational efficiency and more on a local authority's commissioning decision: a local authority may be a small agency's only contractor, and so it is particularly vulnerable to losing its entire client base following a commissioning decision. 60 per cent of independent care agencies are thought to rely on local authority contracts for more than three quarters of their business, with almost 15 per cent of providers dependent on local authorities as their only customer.[77]

The market is not distorted to favour one purchaser

In many private markets, some purchasers are given favourable rates (e.g. a discount for a bulk-purchase or in reward for loyalty). This is also acceptable practice for long-term care suppliers, but no single purchaser should be favoured above all others.

Deloitte concluded that the local authorities' commissioning role often made them the single largest purchaser of care in a given location. As no other demand is aggregated, the local authorities' favoured position could often distort the market.

- Care homes rely heavily on block contracts from local authorities. Domiciliary agencies tend to be smaller in size and so rely even more heavily on the local authority - local authority funded older people may account for their entire client base.
- This places local authorities in a powerful position as the single dominant purchaser. They can subsequently set fee rates as a condition of contracting with suppliers which may be too low to provide acceptable returns. Age concern found local authorities could set their fee rate for care homes up to £100 below the homes' average weekly charge.[78]
- This leads to market distortions:
  - Prices differ for identical products: limited options to reduce costs or increase returns via other methods means care homes often cross subsidise to make up for the local authority fee shortfall. They charge older people who pay privately much more in order to make up the losses from their local authority funded counterparts.
  - Market mechanisms to regulate cost and quality are underdeveloped. Consumer choice cannot drive up quality or reduce prices, as 1) self-funders are constrained by their weak market position relative to the local authority and 2) state-funded older people have little direct purchasing power (the local authority purchases care on their behalf.)

[73] Though housing associations, such as Anchor Trust, would get a subsidy from the Housing Corporation when building its care homes
[74] Such as in the US and New Zealand
[75] Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008
[76] Laing, *Trends in the London Care Market 1994-2024* Kings Fund 2005
[77] NHS Health and Social Care Information Centre. NHS Staff 1996-2006. Figure from 2006. NHS Health and Social Care Information Centre (2007)
[78] Age Concern, The Age Agenda 2008: *Public policy and older people*, February 2008

Examples of cross-subsidisation:

The 2006 Wanless review cited a case brought to Age Concern:

An older person had been temporarily covered by a local authority contract while her house was sold. The contract price for the local authority was £356 a week. But when the house was sold and the user became a self-funder with her own contract, the price went up to £520 a week.[79]

Care home fees	Somerset	Surrey	East Sussex
Local authority base fee	£464	£566	£436
Private fee	£597	£785	£597
Difference	£133	£219	£161

Buyers can make informed choices based on accessible information

In long-term care, brokerage, information and advice services should be available to guide older people on their eligibility for care and financial support, and on their care choices and the financial implications of these. Older people and their families should be able to make informed choices about care based on this information.

Deloitte concluded that this is rarely if ever the case in the current market:

- There is a shortage of information and advice services, and supply is locally variable. Age Concern recently reported a cut in Government funding in 2008 of 80 per cent their local advice centres.[80]
- The current system of means and needs eligibility rules, exemptions, and the interaction with state benefits is extremely complex. Even if perfect information existed the current market is too opaque to enable fully informed choices.
- Anecdotal evidence suggests incentives exist to restrict information to consumers as a means of reducing the demand (rationing) services and benefits.[81]
- The marketing/advertising functions of suppliers are under-developed, as attracting individual clients is not as necessary to survival in the current market as winning new local authority contracts. This contributes to low consumer awareness of the services available, particularly in the domiciliary sector.

Fairness:

A single set of rules are applied to all

A basic tenet of "fairness" in long-term care is a general rule of law - the same rules should apply to everyone in a given situation. People with the same need for care should be treated the same within the market.

Deloitte concluded this was not often the case in the current market. For example:

- Older people with identical care needs can be deemed eligible or ineligible for state support depending on where they live, due to local variation in needs-based eligibility criteria. Outcomes can also vary on a case by case basis in the same local area due to variation in interpreting criteria by front line staff.
- Those ineligible for state subsidised care may receive no further support from the local authority. They may not therefore have access to the same needs assessments or information services as those given local authority funding.
- Due to cross-subsidisation, self-funded care home residents may pay much more than the fees negotiated for local authority funded residents in return for identical services.
- Assessments to identify the need for NHS and social forms of care (the former free, the latter means tested) can lead to high-stakes outcomes based on local interpretation of eligibility criteria. An individual who requires high-level nursing care could have all their fees paid by the NHS, whilst another with the same high need in another location, or a chronic condition which may not fall so clearly within NHS continuing care criteria, might have to pay costs privately.

Everyone can access the care they need without financial hardship

In long-term care, those who cannot afford the care they need should be supported by the state. Those who can afford to pay for the care they need should be able to do so without taking on a prohibitive financial burden.

Deloitte concluded a growing proportion of older people are having to meet unaffordable care costs:

- Eligibility criteria is tightening so that older people with very low wealth levels will still not receive state supported care, unless they also have very high care needs. As such, a growing number of older people with relatively high needs are not receiving state support, and will have to pay for more expensive care packages themselves. Such care packages may be beyond the financial limits of lower earners.

[79] Wanless, D, *Securing good care for older people: taking a long-term view*, King's Fund, 2006
[80] http://www.ageconcern.org.uk/AgeConcern/D77602CDF8A2495F86B3472706AB9865.asp
[81] Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008

- It is also unlikely that more complex care packages can be delivered effectively by informal care.
- Financial planning for care needs is poor:
  - Private insurance is significantly under-used. As such, there is little risk pooling in long-term care, despite a 1 in 4 chance of requiring care in old age. Therefore, individuals who require care may shoulder the entire financial burden themselves.
  - Equity release is under-used to older people cannot access capital from their homes to pay for potentially more expensive care without selling their homes. This lack of access to funding suppresses demand for a wider range of care services and limits choices for care users to mainly domiciliary or residential care.
  - There seems to be little awareness of other alternatives, such as local authorities' deferred payments schemes.

People can reasonably expect to "get something back"

In a re-distributive and progressive society, what individuals receive from the state may not necessarily match their lifetime contributions. Nevertheless, a fair assumption is that people who contribute as citizens all of their lives will receive "something" from the state in their old age. In a long-term care context, this "something" may or may not be financial support, but older people may reasonably expect help to access the care they need.

Deloitte judged that a decreasing number of older people receive "something" back from the state.

- Tightening needs-eligibility criteria means even those with relatively high needs and low wealth levels may not receive any financial support from the state.
- Those who receive no financial support from the state are often excluded from other forms of support (e.g. guidance on how to buy their care privately) and are "sign-posted" out of the system. Their care outcomes are not often monitored.

Section Four: The future

The previous section has highlighted a number of weaknesses in the current long-term care market, which undermine both its efficiency and fairness. However, this assessment is very much a snapshot of the current market, and does not take into account key trends that may significantly affect the market in the short and medium term.

Deloitte has identified four market developments that are likely to change the functions of the current market. These have the potential to alleviate or exacerbate some of the weaknesses already identified. There are, of course, many other potential developments and trends that may offset or reinforce the impacts of the market developments described here - for example, changes in the caring workforce as a result of immigration or wage trends would certainly have a huge impact on the market. Nevertheless, the four developments outlined below demonstrate the transitory nature of the current market and its sensitivity to future social, political, economic and demographic trends.

Market development one: the introduction of personal budgets

The roll out of personal budgets began with the Transformation Programme on 1st April 2008. Implications include:

- Greater use of personal budgets is likely to disaggregate demand.[82] This can increase transaction costs for suppliers as they move from a small number, perhaps even a single contract client (i.e. the local authority) to tens or hundreds of individually contracted personal budget holders.
- Supply of care may become more unstable in the short term. Disaggregated demand means a wider range of consumer preferences expressed, and more consumer choice between suppliers. Small suppliers in particular are vulnerable to being driven out of the market whilst others may enter the market in order to meet the unmet demands of new personal budget holders.
- The need for advice and information will grow as more people become responsible for their own care spending decisions. A potential lack of oversight regarding what older people spend their personal budgets on could mean the current shortage of available advice and information has serious consequences for larger numbers of people.
- Overall, however, the introduction of personal budgets should lead to a closer relationship and clearer channels of communication between supply and demand. This should make supply of care more responsive to both the volumes and the nature of demand, meeting people's actual needs more closely.
- Personal budgets are only available for local authority funded individuals, and this development will not resolve the tightening eligibility criteria for state funding. Nevertheless, personal budgets may mean that self funders will no longer be in a weak purchasing position, but will have similar standing to personal budget holders. This should end their differential treatment by suppliers.

[82] This does not exclude the possibility that over the longer term, a new market of "aggregators" will emerge, acting as brokers for personal budget holders and buying in bulk on their behalf

Market development two: funding increases remain broadly constant

The 2007 CSR announced a three year funding settlement representing a 1 per cent annual increase in real terms for long-term care. There is a broad consensus that this settlement is extremely tight, and may not meet increasing costs. If there were no significant increases beyond this settlement, we might expect:

- Local authorities to continue to respond rationally to restricted budgets, by:
  1. Rationing the amount of care they fund, understandably reserving limited resources for those in greatest and most urgent need.
  2. Attempting to make their limited resources stretch as far as possible, by securing the best deal possible with suppliers of care.
- These two behaviours will become more prevalent as the funds available for long-term care do not match increasing costs (brought about by demographic change, see below). This means:
  1. The continued tightening of needs eligibility criteria so that only those in the most critical need receive funded care.
  2. Local authorities maintaining and potentially driving down the fees they are willing to pay suppliers for caring for state funded older people.
- Such developments may have a number of consequences. Primarily, local authorities forced to focus resources on high-need and remedial care will find they are spending more in the longer term, than if they had been able to cater to low level and preventative care. This suggests a vicious circle of ever tighter budgets as resources are inefficiently spent.
- Secondly, by rationing care to fewer older people, the number of self-funders in a given location may rise. The local authority could lose its dominant market position as single largest purchaser, and with it its ability to negotiate very low fees with suppliers. This could add further cost pressures to local authorities in the longer term.

Market development three: technological advancement changes the nature of care in the home

Advances in the technology of ageing - in particular Telecare[83] - could have a fundamental impact on the way in which care is supplied in the future. Wanless cites the following examples:

- It can prevent or defer an older person's move into a care home or hospital.
- It can reduce or replace some of the routine input needed from carers, formal and/or informal, in the home setting, permitting them to be more effectively deployed.
- It can speed up an older person's discharge from hospital by providing added support in their own home or in another intermediate care setting, thus freeing up hospital beds.
- It can help someone maintain a healthier lifestyle, thereby reducing or delaying future needs.
- It can improve efficiency within a care home and help keep down costs.
- Using wireless technology, much of the available equipment can be installed in existing homes and removed when no longer needed.[84]

It is clear that technology, in the form of falls prevention and low level monitoring, can help postpone and potentially reduce overall the need for more intensive care services provided in care homes or hospitals. Whereas high level monitoring (e.g. provided by "third generation" telecare programmes which can monitor people getting out of bed in the night, whether they have left an electrical appliance on, etc.) could prove a replacement to some and supplement other common domiciliary services.

Overall, technology has the potential to reduce care costs and keep people living independently in their own homes for longer. This may help to offset the impacts of other market trends, such as the increased costs associated with an ageing population (see below).

The slow take up of telecare technologies, in spite of mounting evidence quantifying the potential cost savings and government statements to support such initiatives, suggests a more evolutionary shift towards technology-based care. Nevertheless, Wanless estimated in 2006 that 1.5 million older people were already using personal alarms around the home for emergencies, which is the most common first step towards a technologically enabled home.[85] The Government's housing strategy for an older population, which outlines a framework for a "life time home" standard for new builds, may also generate fresh impetus for innovation.[86]

[83] The Audit Commission describes Telecare as: any service that brings health and social care directly to a user, generally in their own homes, supported by information and communication technology. (Audit Commission, 2004)
[84] Wanless, D, *Securing good care for older people: taking a long-term view*, King's Fund, 2006
[85] Ibid
[86] http://www.communities.gov.uk/housing/housingmanagementcare/housingolder/

Market development four: the population ages according to demographic predictions

Based on statistics from the Government Actuarial Department, the PSSRU and the Wanless Review of Social Care, among others, have predicted a large increase in older people (particularly over 85s) relative to overall population growth. With this ageing population comes an increase in long-term health conditions requiring intensive care packages, as well as an increase in mental health conditions, such as dementia.[87]

The impact of an ageing population will increase long-term care costs. This is because:

1. There will be more older people to cater for in the market - larger volumes of older people will lead to an increase in demand for formal care, and an increase in both self-funders and those eligible for state funding.
2. People will be living longer, potentially leading to greater time spent requiring long-term care.[88]
3. Predicted increases in complex care needs (such as dementia) will increase the overall costs of care packages that local authorities may have to fund.

Analysis has already suggested an increase in funding of 325 per cent in real terms will be required by 2041, in order to provide today's level of care to the greatly increased numbers of older people (assuming people will have similar rates of functional disability as today and not live for much longer in good health).[89]

Overall, the increased volume of potential and real demand associated with an ageing population will increase cost pressures on the current market. Assuming moderate funding increases in the medium term, it is likely local authorities will continue to reasonably respond to limited resources, as we explain above, by both rationing the funded care they provide to target those in most need, and trying to make their funding go further by negotiating tighter fees with care suppliers. However, given the increasing volumes of demand we might expect, two points need to be borne in mind:

1. To achieve affordability with such an increase in older people, it is likely eligibility for state funded care will be rolled back to only those with "critical" needs.[90] Although this is the highest category on the assessment spectrum, it is possible that local authorities may interpret this even more stringently on the ground, thereby reserving their limited funds to only "very" critical cases.

   This may have a significant impact on NHS costs. As fewer and fewer older people are given any preventative care, it is likely more will reach a level of need so high as to qualify for NHS care more quickly. Therefore the burden on the NHS will rise as NHS funding will have to care for a larger number of older people for a longer period of time.
2. Even rationing state funded care only to those with the very highest "critical" conditions may not be sufficient to keep local authority costs down. This is because greater volumes of older people overall will also mean greater volumes of older people eligible for state funded care (i.e. those with the most critical care needs, even if people do start to live healthier for longer).

Section Five: Conclusions and next steps

In order to gain a holistic picture of long-term care for older people, we asked Deloitte to apply a conceptual framework. This framework - exploring long-term care as a market - has provided both an insight into how long-term care currently functions, as well as allowing for a systematic assessment of its fairness and efficiency. The weaknesses that have been identified by the Deloitte analysis can be grouped under five themes:

1. Informal care
2. Navigation
3. Funding
4. Local market management
5. Responsiveness of supply

Informal care

The majority of older people rely on informal care to meet their care needs. The long-term care market delivers only a small proportion of the care provided to the older population in need. This has two consequences:

1. It reduces considerably the level of demand the formal market might otherwise have to meet. This is because many of those receiving informal care do so by choice, and therefore never approach the local authority or care suppliers for formal services. This also significantly reduces the potential costs to the state - Carers UK estimate that carers of older people save the state £58bn a year in care replacement costs alone.[91]

[87] For example, the 2006 Wanless Review estimated that the number of people aged 85 and over in England is set to increase by two-thirds, compared with a 10 per cent growth in the overall population. Over the 20 years to 2025, the Review projected a rise in the number of older people who do not require care of 44 per cent, a 53 per cent increase in those with some need and a 54 per cent increase in those with a high level of need.

[88] Although there is an argument that increased life expectancy will also lead to compressed morbidity - meaning the future's older people will remain healthier longer and not require an extended period of care at the end of their lives. However the PSSRU have concluded that there is no evidence as yet to suggest that decreasing mortality rates would go hand in hand with decreases in functional disability. See http://www.pssru.ac.uk/pdf/rs035.pdf

[89] http://www.pssru.ac.uk/pdf/rs035.pdf

[90] Currently around three quarters of local authorities have set their needs eligibility criteria as substantial or critical - the two highest needs categories in the local FACS assessment

[91] http://www.carersuk.org/Newsandcampaigns/Mediacentre/Tenfactsaboutcaring

2. It reduces the impact and obscures the consequences of a) local authorities rationing care and b) suppliers not setting competitive prices/offering the services older people want. This is because a proportion of those receiving informal care do so by necessity, either because they have been deemed ineligible for state support, and/or the care they can purchase with private resources is too expensive or does not meet their needs.

Whilst these consequences may not be necessarily negative, the knock-on effects of these factors can be:

- The reliance on informal care to dampen the demand for care that might otherwise be state funded is potentially high risk:
  - The CSCI found that informal care relationships can be fragile, so that the consistency of informal care cannot be guaranteed.[92]
  - There is also no means of assuring the quality of informal care - certainly a proportion of older people relying on informal care are not having their care needs adequately met and may be storing up health problems for the future (which the local authority or NHS may eventually have to address).
  - Finally, demographic change over the longer term may render informal care a less viable alternative to formal care - because there will be an increase in older people with more complex care needs, who may find informal care inadequate. In addition, a decreasing birth rate will reduce the numbers of younger relatives available to care for the growing numbers of older people.
- Such reliance on informal care means the volume and nature of latent demand for formal care in the market is obscured, making it harder for suppliers to know how to attract more customers. This lack of market information may limit the amount of care and the range of services offered by suppliers. This risks creating a vicious circle whereby older people cannot find the services they want among formal care suppliers, and so resort to informal care - leaving their demands unexpressed and suppliers still unaware of this untapped market.

Navigation

Two key flaws in the current long-term care market combine to create a significant information asymmetry.

- The first is that there is a shortage of accessible information and advice services to assist older people and their families to make care choices and access the services and benefits they may be entitled to.
- The second is that the current care eligibility and benefits system is extremely complex, locally variable, and can be subject to interpretation. This means that even if a comprehensive advice service were available, it is unlikely that care users would be able to make informed and rational choices in such an environment.
- This problem is then further exacerbated by the under-developed marketing activity of most domiciliary and residential care suppliers. This is because attracting individual clients is not as necessary to survival in the current market as winning new local authority contracts. This contributes to low consumer awareness of the services available, particularly in the domiciliary sector.

Poorly informed consumers create a number of problems across the market:

- As there is little understanding, and subsequently low awareness, of how the long-term care market functions, people are often unprepared for meeting care costs in later life, a factor which lays behind the low take up of financial products that would help older people pay for their care (such as equity release and long-term care insurance).
- Self funders are particularly vulnerable to information asymmetries, with the CSCI finding this group often make poor choices regarding their care due to the fact that they had been excluded from any information provided by the local authority. This often led to them being "fast-tracked" into residential care through a lack of awareness of the alternatives.[93]
- The opaque nature of the market is also the basis for many of the examples of "unfairness" the Foundation uncovered in its consultation with low earners in 2007. These included: having to "fight" or somehow manipulate the system in order to access benefits and services, the local or indeed case-by-case variation in outcomes, and the sense that the government cynically uses poor information to ration care.[94]

Funding

The 2007 Comprehensive Spending Review announced a 1 per cent annual increase in real terms for long-term care funding for the next three years. The consensus from local authorities and third sector agencies working in the field was that this settlement was particularly tight and would probably not meet increasing costs.[95]

As the analysis demonstrates above, a lack of resources at local level drives two rational behaviours by the local authority: the first is to focus resources on the highest priority groups - i.e. those more in need of care. This is

[92] Commission for Social Care Inspection (CSCI), *The State of Social Care in England 2006-07*, January 2008
[93] Ibid
[94] Resolution Foundation, *Lost: low earners and the elderly care market*, 2008
[95] http://www.guardian.co.uk/business/2007/oct/10/politics.economicpolicy

done by tightening eligibility criteria. The second is to make resources "go further" by negotiating lower fees with care suppliers for state-funded older people. These behaviours can drive a range of inefficiencies:

- By targeting resources on intensive and remedial care, local authorities are not investing in preventative services which may reduce costs later on. As such, authorities may find they spend more over the longer term by only stepping in when people's care needs have escalated, thus creating a vicious circle of inefficient spending.
- Second, by tightening fees negotiated with care suppliers, local authorities are indirectly encouraging more and larger cross-subsidisation between local authority- and self- funded older people. This is likely to price self-funders out of the market, or lead to the running down of private resources faster than might otherwise be the case. In either case, the funding burden is likely to fall back on to the local authority prematurely: by making state funding "go further", the local authority is in fact helping to use up private funding more quickly and thereby add to the numbers of state-funded older people.

However, it is not just state resources which are being used inefficiently in the long-term care market. Private funding is also being channelled inefficiently. Low awareness of how long-term care operates and generally poor financial planning in the UK means the financial services market is particularly under-developed in this field. A YouGov survey commissioned by the Foundation in December 2007 found, for example, that 38 per cent of respondents stated they had no current provision to cover their care costs, and had no idea how they would pay for it.[96] Equity release products and long-term care insurance - the two key product types currently available to consumers to help them meet their care costs - have very low take up. This increases the costs of these products to the consumers who do buy them, and keeps supply (and therefore choice of products) low. More specifically:

- Under-use of equity release products could mean fewer people are able to receive care in their own homes. This is because many older people are asset rich, income poor, and so if they require domiciliary care, they may be unable to afford this from their liquid savings. But without an equity release product, they are also unable to convert any of the capital in their homes into spendable funds to pay for such services. Their only option may be to sell their home and downsize, or move into residential care prematurely.
- It is possible that the shortage of spendable private funds is one of the reasons why a wider range of non-residential care alternatives are not available in the UK, relative to other countries - older people do not have the resources to stimulate the market for these other options. The emerging extra-care market suggest this situation may be changing, though could be a result of more diverse local authority commissioning decisions rather than individual consumers having more purchasing power.
- The under-use of long-term care insurance, on the other hand, has made the premiums for those who do have insurance quite high, further dampening demand for such products. In addition, the overall lack of risk-pooling in the long-term care market means that the costs for those who do need care are not shared or spread in any way. Given that one in four people will require care in old age, the fact that most care users will probably bear 100 per cent of the costs of their care does not capitalise on a clear opportunity for more affordable, risk-pooled care.

Local markets

The long-term care market operates on the ground as a diverse set of local markets, each with their own characteristics of demand and supply. Much of this variation is driven by the intermediary role of local authorities.

For example, local authorities set needs based eligibility criteria, interpret this and means based eligibility criteria, and commission in response to this, differently. This can generate a number of weaknesses in the market overall:

- Local variation in eligibility criteria leads to local variation in people's access to care and funding available to them, whereas locally set fees for care homes and domiciliary care influences the nature of supply, and the numbers of older people able to afford to purchase care services privately. Both of these, in turn, lead to widely different outcomes for older people with potentially identical needs, based on where they live. More consistency of access through national eligibility benchmarks would resolve this issue, however, this risks removing local authorities' ability to control their care budgets - crucial in an environment of limited care resources.
- The interplay of local market environments exacerbates the complexity of an already complex system, as rules and entitlement vary from location to location. This is particularly problematic for those older people who may have lived in and received domiciliary care in one location, but who have moved to a care home in a neighbouring local authority.
- Another problem associated with local markets is that it is easier for a local market to be dominated by a single purchaser. As we have seen, a local authority's role as commissioner of care means they will often be the

[96] YouGov Poll for Resolution Foundation, sample size for the survey was 2,006 adults. Fieldwork was undertaken from 3-5 December 2007

single largest purchaser in a given location. This in itself is an important and valuable part of the local authority's function, however, combined with a shortage of resources, this can be problematic for care suppliers, who may find they have less control over their fee rates. Suppliers may also have limited opportunities to make economies of scale, as they cannot grow beyond the largest purchaser in a local market to win the contract with a larger "national" buyer, for example.[97] Regional or sub-regional markets could be more effective in this context.

- Nevertheless, as a market supplying a social good, the local authority has an important role to play to ensure both fairness and efficiency for local populations - the market cannot be left to simply regulate itself in such cases. The local authority needs to shape the market - stimulating supply to meet the needs of the entire local population of older people (for example ensuring self funders also get a good deal from their care home fees) and helping smooth the natural local variations that can occur (for example through differences in local labour markets and property prices).

Responsiveness of supply

A final theme which emerges from the Deloitte analysis is the general inability of care suppliers to respond flexibly to demand. Although obscured by people's reliance on informal care, and subject to much local variation, the formal care market more or less delivers sufficient levels of care for those using residential and domiciliary care supply. However, whilst volume may be satisfied, suppliers are far less effective in delivering different *types* of care according to demand. There are a number of reasons why this may be the case:

- Firstly, there is considerable reliance on informal care. As we explain above, this means much demand is "unexpressed", and simply absorbed by informal carers. As a result, suppliers of care are unable to spot unmet demand, niches in the market or opportunities to diversify their services and attract new clients.
- Secondly, a lack of available resources to spend by self funders dampens demand for formal care services, so suppliers do not attempt to create more or wider ranges of care choices to attract their business.
- Finally, the relatively small self-funding market maintains the local authorities' position as the largest single care purchaser. This means suppliers are incentivised to respond to local authorities' commissioning decisions, which, unless based on thorough and accurate local needs assessments, may risk limiting the range of care options commissioned (and therefore available) to the local population.

The impact on low earners

The Foundation decided to explore the issue of long-term care partly because it presents particular challenges for low earners. Low earners, by which we mean those on below median incomes but who are mainly independent of welfare support, are on the cusp of means testing eligibility. This means that whilst many may not be deemed eligible for state funded care (as their asset levels are too high), they may find the costs of care prohibitively high for their relatively small budgets. Given the high costs of residential and domiciliary care, it is likely that low earners would spend a larger proportion of their weekly budgets on care costs than both higher and lower earners, and run their modest assets down quite quickly.

The findings from Deloitte's analysis also identify some other potential challenges: the Foundation's research demonstrates that low earners are more likely than average to own their own homes outright. It is likely that many of the 70 per cent of low earners with assets over the upper means testing benchmark[98], who are potentially ineligible for state funded care, are pushed over this threshold due to the capital in their homes. And yet, most are unable to access this capital to spend on care.[99] For those in such situations, options are limited: sell their home and downsize, using the remaining capital to purchase domiciliary care; sell their home and move into residential care (perhaps prematurely); or resort to informal care.

Given the situation faced by many low earners who must self-fund - i.e. not being able to afford care without selling their homes - it is understandable that informal care plays a vital role in meeting care needs. The Foundation's research found that low earners are 25 per cent more likely than average to be informal carers.[100]

However, the situation for low earning care users, and their carers, is set to become worse: as needs eligibility tightens, the number of self funders with relatively much higher needs will increase. These older people will, by definition, require more intensive and expensive care packages. Few low earners will be willing or able to meet these higher care costs. Therefore, thanks to tightening needs eligibility, reliance on informal care is likely to grow[101] (particularly among lower earners), and these carers are likely to be faced with a larger care burden, in which they must provide more hours of more intensive care. Taking time off work to provide such support can have a significant impact on the incomes, pensions contributions and general quality of life

[97] Laing and Buisson, *Care of Elderly People Market Survey 2007*
[98] Resolution Foundation, *Lost: low earners and the elderly care market*, 2008
[99] Due to poor take up of equity release and other draw-down products
[100] This is likely to be because lower earners rely considerably on informal care, and their low earning families provide this; but may also be because carers tend to give up work or work part time to fulfil their caring duties - thereby pushing them into the "low earning" income bracket
[101] Carers UK estimate there will be 9 million carers by 2037 - see http://www.carersuk.org/Newsandcampaigns/Mediacentre/Tenfactsaboutcaring

of carers, particularly those who may have already been on low incomes.[102]

It is clear, then, that the weaknesses in the current market may have negative consequences for all users, current and future, of long-term care, unless steps are taken to address some of the weaknesses we identify above. Nevertheless, low earners, caught as they are on the cliff-edge of means tested eligibility and often unable to access the capital which drives them over this edge (i.e. their homes), face a particularly challenging situation. Their situation illustrates how the current market's numerous weaknesses are not felt universally - they can converge to the particular disadvantage of groups of older people and their families.

The need for reform

Our attempt at portraying long-term care conceptually demonstrates how the market operates as a set of inter-dependent parts, all working more or less effectively but nevertheless in unison to achieve a single outcome (i.e. delivering long-term care to those in need). As such, the individual weaknesses we identify based on the Deloitte analysis must be considered in the round. If one, or even a few, areas are targeted for reform in isolation from the whole, this may have knock on effects which de-stabilise other parts of the market.

Another point that must be borne in mind is that the market developments identified by Deloitte, described above, illustrate just how transitory the conditions of the current long-term care market are. The market is sensitive to numerous political, economic and demographic trends, which can re-shape the market map presented here beyond recognition. This again reiterates the need for a whole-system approach to reform, which can achieve sustainable outcomes in the face of changes likely to occur in the field of long-term care.

The Deloitte analysis demonstrates that there is scope for greater efficiency and fairness in the market within existing resource constraints. Nevertheless, this analysis and a wealth of other research does suggest that further resources will be needed to improve and expand the long-term care market in the future. It is important, however, that a reform programme and funding settlement work hand in hand. The current market needs to be made "investment ready" i.e., made to operate more efficiently so that it can make the most of new resources that may be forthcoming.

In short, reform needs to be based on an overall vision of what an efficient and fair long-term care market ought to look like in the future. This vision would create a unifying outcome which individual reforms to specific parts of the market could work towards, providing greater consistency, and impart a "long term view". Such a vision could become an extremely powerful, multi-generational settlement if it were subject to political consensus, and received cross-party, third and private sector support.

Next steps for the foundation

In the next six months, the Foundation will embark on 1) a consultation process with different groups of stakeholders to explore what a fair and efficient long-term care market ought to look like, and 2) a series of research projects exploring in more depth and developing potential solutions to some of the key areas of weakness identified above. These two streams of work should enable us to construct a coherent vision of a long-term care market, which is fair, efficient, and can withstand future developments which may alter the environment in which the market operates.

[102] It is expected that the forthcoming Carers Strategy will address some of these issues to help carers stay in work or receive financial support.

Notes:

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BUN2107