Northern Ireland Assembly

Research and Library Service Briefing Paper

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Support Provision for Carers

Summary

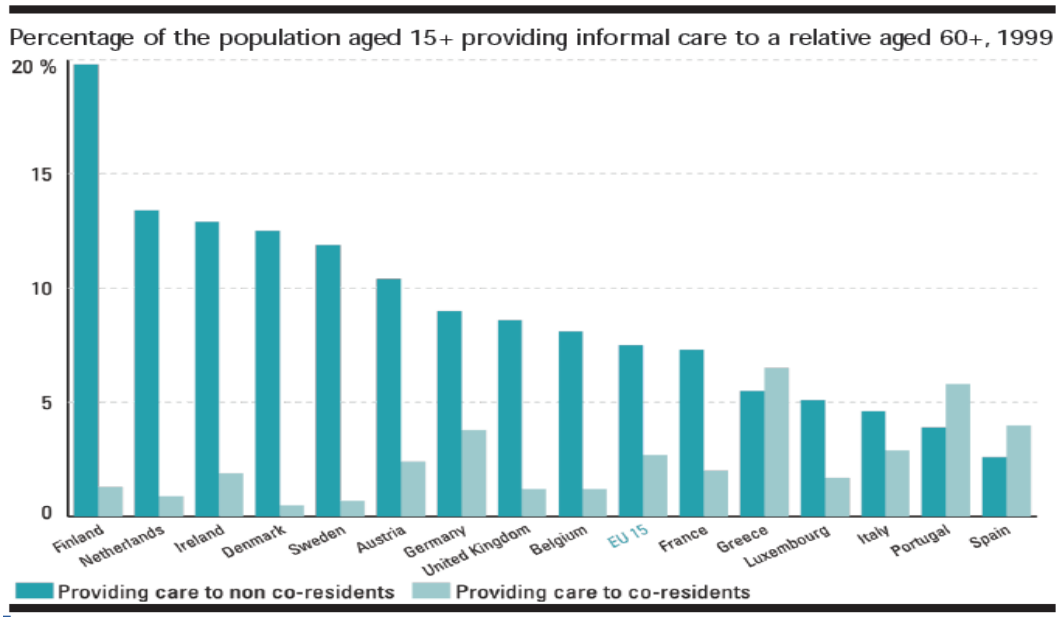
This paper provides a description of informal carers and the support available to them across Europe. It summarises the variety of benefits and allowances currently available, including the link between current support for carers and the Rate Relief Scheme in Northern Ireland. It concludes that while there may be some options for extending rate relief for carers here in the short term, this would have to be reconsidered in light of proposals in England for free personal care at home and a new National Care Service, assuming Northern Ireland continues to adhere to the principle of parity with GB.

1 Introduction: Some Facts and Figures on Carers

"Carers are people who, without payment, provide help and support to a family member or a friend who may not be able to manage without this help because of frailty, illness or disability. Carers can be adults caring for other adults, parents caring for ill or disabled children or young people who care for another family member." (Department of Health, Social Services & Public Safety)[1]

[1] DHSSPS definition of carers - http://www.dhsspsni.gov.uk/index/hss/ec-community-care/ec-carers.htm

According to Hoffmann and Rodrigues[2], family carers across the EU provide over 80% of all care, with women providing approximately two-thirds of care mainly as daughters, daughters-in-law, wives or partners. Their report includes the following comparative chart which, although a bit out of date (i.e. based on 1999 data), provides some indication of the extent and variation of informal care for elderly relatives across the EU15 countries.



Estimates of the numbers of carers in the EU vary according to the definitions used, and the methods used to identify carers. Significant differences in patterns of family obligation and formal welfare services between the older and newer member states mean that figures from the EU15 cannot simply be scaled up to reflect current EU membership.

A recent report on care provision commissioned by the European Commission estimates that 32 million people are actively caring on a daily basis across the EU27, and that between two and four per cent of children and young people are likely to be caring for a disabled or ill relative.[3]

Most of the information available on carers relates to family carers looking after old people. The 2005 Eurofamcare Study, for example, which included 23 National Background Reports and six National Surveys (Germany, Greece, Italy, Poland, Sweden and the UK), provides a picture of the average carer of an older person as follows:[4]

[2] Hoffmann, F. & Rodrigues, R. (2010) "Informal Carers: Who Takes Care of Them?", Policy Brief, April 2010, European Centre for Social Welfare Policy and Research, Vienna - http://www.euro.centre.org/detail.php?xml_id=1714

[3] Glendinning, C., Tjadens, F., Arksey, H., Moree, M., Moran, N. & Nies, H. (2009) 'Care Provision within Families and its Socio-Economic Impact on Care Providers'. Social Policy Research Unit, University of York and Vilans Centre of Expertise for Long-term Care, Utrecht. Working Paper No. 2342, European Commission DG EMPL, May 2009 - http://www.eurocarers.org/userfiles/file/research/UniofYorkReport1109.pdf

[4] Summary of main findings from EuroFamCare, February 2006 - http://www.uke.de/extern/eurofamcare/documents/deliverables/summary_of_findings.pdf

- 76% of main carers of older people were women
- the mean age of carers was 55 years old
- nearly 50% of family carers were children of the older person, 22% were partners/spouses
- forty-eight per cent of carers lived in the same household as the person cared for; 18% lived within walking distance; about 25% of carers lived further away from the care recipient than ten minutes by car or public transport
- many carers cared for 24 hours a week; the average was 45 hours a week
- over two thirds of carers had provided care for more than two years, most often in Poland (74%) and least often in the UK (60%)
- 41% of carers were also in paid work
- the average duration of an episode of caring for an older person was five years

Available data contained in the National Background Reports is summarised in the same report as follows:[5]

UK

- One in four carers of older people cared for 20 hours a week or more.
- One in ten carers of older people cared for 50 hours a week or more.
- One in five carers cared for at least ten years.
- 45% of carers cared for five years or more.
- 52% of all carers of older people cared for their parents(-in-law).

Ireland

- 40% of carers cared for more then 20 hours a week, 27% for more than 50 hours.
- Half of all carers looked after parents(-in-law), 25% cared for a spouse, 25% cared for other relatives, neighbours or friends.

Netherlands

- Standard administrative criteria define carers as those providing care for more than eight hours per week and/or longer than three months. 2.4 million (19%) of the Dutch population older than 18 are carers according to these criteria. 750,000 care for more than eight hours a week and more than three months.
- 44% of all carers are middle aged women caring for parents(-in-law).
- Among carers providing 20 hours plus of care a week, care for parents is most common. Twenty hours plus care each week is provided by one in ten carers of parents(-in-law).

[5] Glendinning, C., Tjadens, F., Arksey, H., Moree, M., Moran, N. & Nies, H. (2009) 'Care Provision within Families and its Socio-Economic Impact on Care Providers'. Social Policy Research Unit, University of York and Vilans Centre of Expertise for Long-term Care, Utrecht. Working Paper No. 2342, European Commission DG EMPL, May 2009 - http://www.eurocarers.org/userfiles/file/research/UniofYorkReport1109.pdf

Austria

- The criterion for identifying carers is the provision of 15 hours or more care per week. A quarter of carers of older people provided more than 15 hours care per week.
- Data on carers of Long-Term Care Allowance recipients showed that:
  - 38% provide up 20 hours a week care
  - 30% provide 21-40 hours a week care
  - 32% cent provide more than 40 hours a week care.

Italy

- There is no direct or proxy data on the number of carers spending 20 hours plus a week caring. The average number of hours of care provided is 92 per week, which presumably also includes care for children and relatives who are not old, sick or handicapped.
- 11% of people aged 50 plus cared for an older person.

Poland

- There is no national research on family carers, only regional studies. Estimates are derived from data on the numbers of disabled elderly people.

Czech Republic

- There is no national data on carers. Estimates derived from the number of disabled older people suggest 500,000 carers. No information is available on hours of care they provide each week or the duration of care-giving.

Sweden

- There is no national, representative data on carers; estimates have instead been derived from the numbers of disabled elderly people. There is no information available on hours of weekly care or the duration of care.

Slovenia

- There is no national research on carers. Estimates are derived from the numbers of disabled elderly people.
- One study found that 12% of people aged 65 plus could not care for themselves, nor could 30% of people aged 70-plus and 60% of those aged 80-plus. Of those older people that received help from their relatives, two-thirds received help several times a week and half every day.

The National Surveys conducted as part of the Eurofamcare Study also provided some insight into the types of care provided by family carers (FCs) caring for old people (OP), and some of the issues arising, in the table below:[6]

[6] Glendinning, C., Tjadens, F., Arksey, H., Moree, M., Moran, N. & Nies, H. (2009) 'Care Provision within Families and its Socio-Economic Impact on Care Providers'. Social Policy Research Unit, University of York and Vilans Centre of Expertise for

Note: Information in table below is based on Eurofamcare National Surveys of Germany (DE), Greece (EL), Italy (IT), Poland (PL), Sweden (SE) and the UK. [7]

WHAT are the OP's needs for care and help as reported by FCs?

SURVEY RESULTS	ISSUES ARISING
Domestic needs: e.g. housework	
All countries: **92%** [2] (High IT 95%, Low EL 86%)	OP with a FC are least likely to get domestic care services either because limited home care services have to focus on isolated OP e.g. EL, or because home care services are having to provide more intensive care for fewer but more dependent OP e.g. UK. The wealthier can pay for such a service.
Emotional/psychological/social needs: e.g. companionship, reassurance	
All countries: **89%** (High IT 96%, Low SE 85%)	A very important need not classically considered as a responsibility of home care services, even though day care, Alzheimer cafes, and community centres may fulfil this function. Such services are important for both working carers and non-working carers as a way of providing respite care during the day. The potential role of volunteers in providing emotional and psychological support to the OP and thus respite to the FC needs to be further developed and better integrated with formal care services.
Mobility needs: e.g. inside or outside the house, transport	
All countries: **82%** (High IT 95%, Low EL 72%)	Mobility aids, technical adaptations and the wider introduction of IT based technologies in home, are services that need to be further developed by LAs, NGOs. More information about their availability must be provided. Half of SE respondents got such technical adaptations but few in other countries. Outside the house: environmental modifications and the adoption of new building standards in all built environments need to be actively promoted by services, NGOs and LA planning departments. Special transport services were almost absent in EL and PL, compared with SE where 38% had such access.

Long-term Care, Utrecht. Working Paper No. 2342, European Commission DG EMPL, May 2009 - http://www.eurocarers.org/userfiles/file/research/UniofYorkReport1109.pdf

[7] Glendinning, C., Tjadens, F., Arksey, H., Moree, M., Moran, N. & Nies, H. (2009) 'Care Provision within Families and its Socio-Economic Impact on Care Providers'. Social Policy Research Unit, University of York and Vilans Centre of Expertise for Long-term Care, Utrecht. Working Paper No. 2342, European Commission DG EMPL, May 2009 - http://www.eurocarers.org/userfiles/file/research/UniofYorkReport1109.pdf

Financial management: e.g. paying bills for the cared for from the OP's own money	
All countries: **80%** (High IT 92%, Low UK 67%)	This is a significant area of need and a major responsibility for FCs, and highlights the problems of protecting vulnerable OP living alone and/or using services from financial mismanagement and theft. It needs practical organization and legal safeguards regarding the everyday management of the OP's resources. This need may also reflect memory and mobility problems or low educational levels amongst the existing generation of OP needing care.
Organising and managing care and support: e.g. contacting services	
All countries: **79%** (High IT 94%, Low UK 71%)	Meeting OP's complex needs calls for good coordination and management to effectively cover 24 hour and year round responsibilities. The cost effectiveness of integrated care services and teams needs to be evaluated, including care managers. Continuity of care by providers is a critical issue.
Health care needs: e.g. assistance with medication, medical treatment, rehabilitation, therapy etc.	
All countries: **79%** (High EL 88%, Low UK 66%)	This reflects the need OP have for support from FCs when utilising health care services, e.g. making appointments, accompanying, collecting prescriptions and ensuring correct medication, preventive and rehabilitative practices, diet etc. This need overlaps with the management of care and with personal care, but formal assessment rarely takes such tasks into account; new technologies may aid in this area (a *Good Practices Report* for examples is planned to be published on the EUROFAMCARE-website).
Physical/personal care needs: e.g. washing, dressing, eating or going to the toilet	
All countries: **66%** (High IT 78%, Low PL 46%)	The most dependent OP require daily hands-on care to address their personal care needs on a 24-hour, year round basis and services need excellent organisation to be able to provide the intensity of care required at home in such cases in cooperation with the family carer.
Financial support: e.g. supporting OP by providing them with money	
All countries: **36%** (High EL 53%, Low SE 13%)	While only a third of FCs support OP in this way, country variations e.g. the higher figures for EL and IT, reflect low incomes of OP and have implications for the reported high costs of using services, though this varies substantially between countries.

In Northern Ireland, 184,434 people identified themselves as carers in the 2001 Census.[8] Of this total:

- 46,543 people provided 50 or more hours of care per week;
- 27,933 people provided 20-49 hours of care per week;
- 109,958 people provided 1-19 hours of care per week.

2 Benefits Available to Carers

Carer's Allowance is the main social security benefit paid to carers. Its purpose is to help maintain the income of a carer who has given up the opportunity of being in full-time paid work to provide care for a severely disabled person.

To be eligible for Carer's Allowance, carers must be aged 16 or over and caring for someone (at least 35 hours a week) who is ill or has a disability and is in receipt of one of the following benefits:

- Attendance Allowance
- Disability Living Allowance at the middle or highest rate for personal care
- Constant Attendance Allowance at or above the normal maximum rate with an Industrial Injuries Disablement Benefit, or basic (full day) rate with a War Disablement Pension

If someone else is also looking after the same person, only one of them can get Carer's Allowance. Carer's Allowance is only paid for caring for one person, although it can be claimed by more than one person in a household, such as a couple caring for each other. Carer's Allowance is not affected by any savings the carer may have.[9]

Carers cannot get Carer's Allowance if they are on a course of full-time education (i.e. involving 21 hours or more study per week) or on holiday from a course of full-time education.

They also cannot get Carer's Allowance if they earn more than £100 a week after money has been taken off to allow for expenses (e.g. National Insurance contributions, income tax, half of any money paid towards personal or occupational pension schemes, other work related expenses).

Carer's Allowance is a taxable benefit and the current weekly rate is £53.90. This is reduced by the amount of certain other benefits received, including State Pension. If carers receive certain other benefits at £53.90 or more a week, Carer's Allowance cannot be paid to them as well. Payment of Carer's Allowance is taken into account in full in the calculation of income-related benefits and Pension Credit.

[8] DSD/DHSSPS 'Review of the support provision for carers', September 2009 - http://www.dhsspsni.gov.uk/review-of-support.pdf

[9] http://www.direct.gov.uk/en/CaringForSomeone/MoneyMatters/CarersAllowance/DG_10012525; see also Carers Northern Ireland - http://www.carersni.org/Information/Financialhelp/CarersAllowance/Rules

Carers who cannot be paid any Carer's Allowance because they are being paid another earnings replacement benefit may still have an underlying entitlement to it (i.e. their entitlement to it is acknowledged, even though they do not receive payment).

If a carer receives Carer's Allowance or has an underlying entitlement to it, they will also qualify for a carer premium, worth up to £30.05 per week, on any one of the following benefits:[10]

- Income Support
- Income-related Employment and Support Allowance
- Jobseeker's Allowance
- Housing Benefit
- Council Tax Benefit (in GB) or Rate Relief (in NI)

Claiming Carer's Allowance can affect the carer's (or their partner's) other benefit entitlements and can also affect the amount of benefit the person they are caring for receives. The person cared for could lose the severe disability premium in their income-related benefit or the addition for severe disability in their Pension Credit.

At March 2009, 51,662 carers were entitled to Carer's Allowance in Northern Ireland. Figures from 2005 to 2009 indicate a trend of increasing entitlement:

- 2004/05 – 44,918
- 2005/06 – 45,826
- 2006/07 – 46,868
- 2007/08 – 49,211
- 2008/09 – 51,662

The corresponding amounts of Carer's Allowance paid to carers were:

- 2004/05 - £84,664,000
- 2005/06 - £82,105,000
- 2006/07 - £84,083,000
- 2007/08 - £86,976,000
- 2008/09 - £90,401,000

Carers can also receive direct payments from their local trust to buy services from an organisation or to employ somebody to provide assistance. Direct payments are available for anyone who has been assessed as needing help from social services. Carers can use a direct payment to purchase the services they are assessed as needing to support them in their caring role. This includes domestic help or support that

[10] NHS Carers Direct - http://www.nhs.uk/CarersDirect/moneyandlegal/carersbenefits/Pages/Benefitsifunabletowork.aspx

may help them maintain their health and well-being e.g. driving lessons or a holiday so they can have time to themselves.[11]

Carers can also obtain financial help to ease exceptional pressure in the form of a Community Care Grant. They can apply for a Community Care Grant if they are also in receipt of Income Support, income-related Employment and Support Allowance, income-based Jobseeker's Allowance, or Pension Credit.

Carers may get an extra amount of Child Tax Credit or may be able to claim for a Disabled Child Premium if they are caring for a disabled child.

Other forms of support for carers include access to day care centres in some areas. Day centres provide a range of care services for people with different disabilities.

Carers can also receive help at home for the person they care for. Care assistants carry out tasks like cleaning, shopping and preparing meals. Domiciliary care workers provide 'personal care', for example helping someone go to the toilet or get washed and dressed. In some cases, carers may be able to choose to employ people to help with care at home.

Some assistance is also available for transport for carers. They can, for example, apply for a car on behalf of an adult or child aged three or over who is entitled to the mobility component of Disability Living Allowance. If caring for a child or adult who has a Disabled Persons Railcard, carers can receive discount when travelling with them.

Many places of interest, including museums, cinemas, sports venues, National Trust properties and English Heritage sites, also offer discounted or free admission to a companion accompanying a disabled person.

3 Parity with Great Britain

Carer's Allowance is provided for under the Social Security Contributions and Benefits (Northern Ireland) Act 1992. However, since the 1946 National Insurance Acts, arrangements have been made in Great Britain and Northern Ireland to co-ordinate the operation of the two bodies of social security law. This longstanding policy of parity between Great Britain and Northern Ireland has resulted in the legislation in Northern Ireland being closely related to the corresponding Great Britain legislation.[12]

The principle of parity means that people in Northern Ireland pay the same rate of income tax and National Insurance contributions and, in return, have access to the same range of benefits, contributory, non-contributory and income-related, paid at the same rates, and subject to the same rules and conditions as people in Great Britain.

[11] NI Direct - http://www.nidirect.gov.uk/index/caring-for-someone/money-matters/direct-payments-for-carers.htm

[12] DSD/DHSSPS 'Review of the support provision for carers', September 2009 - http://www.dhsspsni.gov.uk/review-of-support.pdf

The Northern Ireland Act 1998 also provides for consultation and co-ordination on social security, child support and pension matters between Northern Ireland and Great Britain, with the intention that single systems should operate across the UK to the extent that the responsible Ministers agree.

4 Support for Carers in Other Regions

The European Commission Report[13] notes that measures differ widely according to their underlying rationale, target group, eligibility criteria, interactions with formal care services, level of payment and whether they are means-tested or not. They are often embedded in the social protection and welfare systems of individual countries, so their transferability to other countries is limited. There are a few instances in which measures offering financial support for carers are available at regional level and do not even extend across the country as a whole. The objectives of financial measures can also vary widely, depending on countries' labour market structures, the extent to which formal long-term care services are available, and attitudes towards the roles of families (and women within families) in caring for older and disabled people.

There are different models of financial support for informal care. All have advantages but also potential drawbacks. Some models direct resources at the person needing care, who uses these resources to employ or provide financial support for the carer. Other models of financial support provide replacement incomes for carers who cannot earn because of their care responsibilities. Although these models are usually means-tested and very low in value, they nevertheless recognise carers' rights to an independent income of their own and also acknowledge the impact of care on carers' labour market participation. Only in the Netherlands was there an example of limited financial compensation offered to carers simply as a token of recognition of their role.

The report classifies models of financial support for carers across Europe and elsewhere into the following categories:

i. Personal budgets or consumer-directed employment of carers
ii. Care allowances paid to the older or disabled person
iii. Care allowances paid directly to the family carer to replace lost earnings
iv. Paying carers instead of formal social service provision
v. Paying carers in recognition of their care-giving responsibilities

[13] Glendinning, C., Tjadens, F., Arksey, H., Moree, M., Moran, N. & Nies, H. (2009) 'Care Provision within Families and its Socio-Economic Impact on Care Providers'. Social Policy Research Unit, University of York and Vilans Centre of Expertise for Long-term Care, Utrecht. Working Paper No. 2342, European Commission DG EMPL, May 2009 - http://www.eurocarers.org/userfiles/file/research/UniofYorkReport1109.pdf

i) Personal budgets or consumer-directed employment of carers

Instead of receiving services, an older or disabled person needing support can choose to receive a personal budget of an equivalent value to purchase care themselves, either from a nursing or care agency or by directly employing a carer themselves. There is increasing interest in personal budgets as a means of increasing choice and flexibility in long-term care; such schemes exist in the UK, Netherlands, some US states and the Flanders region of Belgium. In the Netherlands and Flanders (and to some extent in the UK) the personal budget recipient can employ a close relative, including a spouse, parent or child, to provide care.

Employing family carers through a personal budget is not universally popular. In the Netherlands, only about ten per cent of all those receiving social insurance-funded long-term care support opt to receive this in the form of a personal budget. In 2007 one-third of budget holders relied only on care provided by relatives, one-third only on care provided by care organisations and one-third on a combination of the two. Older people are more likely than younger budget-holders to employ relatives rather than use agency services.

ii) Care allowances paid to the older or disabled person

Within this model, the cash payment is made to the disabled or older person, with no formal requirement as to how it is used. The only obligation on the recipient may be to acquire adequate care. In many instances, however, the allowance will be paid to or used by a family carer.

Care or attendance allowances are paid in Germany, Austria and France. In Germany, an older or disabled person eligible for long-term care insurance can chose between service 'assignments' up to a specified value or a lower, non-taxable cash benefit (or a combination of the two). The cash benefit option has always been more popular because beneficiaries prefer family care to formal services from strangers.

iii) Care allowances paid directly to the family carer to replace lost earnings

The UK, Ireland and Australia all offer benefits as part of their national social security system to replace the earnings lost by carers who are unable to work or have only minimal earnings because of their care responsibilities. Here, care-giving is treated as a labour market risk similar to unemployment or sickness; carers are assumed to be members of the labour market and have entitlement to an income in their own right. However, the level of the payment is usually very low and eligibility often depends on a strict test of carers' means and assets. It therefore offers only minimal social protection.

The authors conclude that this income maintenance model is not compatible with carers' continuing labour market participation. Eligibility criteria assume the carer has no paid work and probably no other source of income either. On the other hand, it does not preclude either carers or the people they are supporting from also receiving services.

A variation on this approach is to provide carers with income during a temporary leave of absence from work, along with rights to return to the same job.

iv) Paying carers instead of formal social service provision

In a number of Scandinavian countries, family care-giving is formalised within a quasi-employment relationship but it is the local municipality that acts as the employer rather than the care recipient (as with the personal budget model). This model reflects the high levels of female labour market participation in these countries; their continuing relatively high levels of publicly-funded services; and the challenges of delivering formal social services in sparsely populated rural areas.

In Finland, for example, the Informal Carer's Allowance is awarded on the basis of an older person's need for care but is paid directly to the carer by the municipality. The carer contracts with the municipality to provide an agreed level of care according to a care plan. The vast majority of carers employed in this way are spouses or other close relatives and levels of Care Allowances are generally lower than the costs of formal home care services.

v) Paying carers in recognition of their care-giving responsibilities

There are a few examples of payments to carers simply in recognition of their care-giving work.

In the Netherlands an annual 'Compliment for carers' (formally known as the 'arrangement appreciation family care') payment was introduced in 2007. All carers supporting people eligible for long-term care insurance benefits could receive the Carer Compliment, which was worth €250 (tax-free). However, in its first year, only ten per cent of those expected to be eligible applied. This was believed to be partly due to the lengthy and bureaucratic application process. Eligibility criteria have therefore been relaxed recently, and it is now believed that more carers might receive the Compliment, although its value may be reduced slightly.

The Australian Carer Allowance is an income supplement paid simply in recognition of the carer's role. It is paid directly to carers who provide full-time care on a daily basis for a disabled adult, older person or child. It is a universal benefit, not dependent on the carer's income or assets, and is not taxable. It is simply intended to help with the extra costs associated with care-giving. Carers who receive the Allowance may also be eligible for Carer Payment, an income replacement benefit for carers who have no other source of income. The Carer Allowance can be received by carers whether they have paid work or not. There is therefore no loss of benefit, and potential disincentive, for carers who remain in, or move into, paid work.

The authors of the European Commission Report conclude that there is little robust evidence on what works, why it works, and what the impacts are for the carer and/or the person they care for. However, they have listed the following as possible factors contributing to the success of service and practice interventions:

- a ‘package’ of complementary interventions or combinations of different approaches that provide synergy; for example, day care, combined with psychosocial support and practical help for carers;
- tailoring the support to meet the needs of specific categories or groups of of carers and care recipients, such as people with dementia or other mental health problems, and their carers;
- acknowledging the common concerns of carers and care recipients, as well as their separate needs;
- embedding the intervention within existing networks, linked to existing professions; and
- being easily accessible to carers.

5 Recent Reviews of Support Provision for Carers

In March 2010, the Department of Health in England published its White Paper outlining its plans to introduce a new National Care Service.[14] The paper also includes plans to support more people to be cared for in their homes by providing free personal care at home, for those with the highest needs, from 2011 (the Personal Care at Home Act 2010 was passed in April 2010 to amend previous legislation and allow free personal care at home to be delivered by local authorities in England and Wales).

With regards to funding the new National Care Service, the Government’s Green Paper ‘Shaping the Future of Care Together’ set out five funding options: Pay for Yourself, Partnership, Insurance, Comprehensive and Tax-funded.[15]

The Green Paper ruled out Pay for Yourself (on the basis that it was unfair that individuals who could not afford to pay for care would go without) and Tax-funded (on the basis that it would put too high a financial burden upon a decreasing proportion of working-age people). After considering the results of the Consultation, the White Paper concludes that the National Care Service should be based on the approach that received the greatest public and stakeholder support – the Comprehensive option.

The Partnership option in the Green Paper was rejected on the basis that it still leaves people exposed to catastrophic care costs. The Insurance option was rejected because international experience showed that take-up would be low, meaning that risk would not be shared across everyone, and the resulting higher premiums would not be affordable for all.

The Comprehensive option will, it is claimed, support all adults with an eligible care need with a universal entitlement to high quality care, when they need it, whoever they

[14] Department of Health ‘Building the National Care Service’ White Paper, March 2010 - http://collections.europarchive.org/tna/20100509080731/http://dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_114923.pdf

[15] Department of Health ‘Shaping the Future of Care Together’ Green Paper, July 2009 - http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_102338

are, whatever their age, wherever they live in England, and whatever condition leads them to need care. It will provide support based on need, not on the ability to pay. The costs of care, which are described as currently indiscriminate, unpredictable and often catastrophic, will be shared collectively, fairly and transparently, between the state and individuals. It will therefore protect people's savings and assets, in exchange for an individual contribution.

The comprehensive National Care Service appears to be based on the same model as the National Health Service. It is described as accessible, easy to understand and providing peace of mind, as people will know in advance how much they will need to pay and that their care will then be provided by the state free when they need it.

The paper sets out three stages of reform - building on the best of the current system; putting the building blocks in place; and, finally, putting in place a comprehensive National Care Service after 2015. It expresses the Government's commitment to the comprehensive National Care Service as follows:[16]

> *"The Government is committed to a comprehensive system, in which everyone is protected against the catastrophic costs of care and in which no one is faced with needing to lose their home or their savings to meet their care costs. A comprehensive National Care Service, which guarantees this, will be the goal of a third and final stage of reform.*
>
> *The comprehensive National Care Service will provide high quality care, for all adults in England, free when they need it. Everyone with an eligible care need will have all their assessed care costs met by the state. Support will be provided for all forms of care: at home, in the community or in a residential setting. This support will be provided by local authorities in a personal budget, which individuals can then spend how they wish in order to meet their care and support needs."*

The paper sets out six principles for the National Care Service:[17]

> *"The National Care Service will be underpinned by six founding principles. These principles are enduring, and will be the foundation of the National Care Service in the future. It will:*
>
> ***Be universal** – supporting all adults with an eligible care need within a framework of national entitlements.*
>
> ***Be free when people need it** – based on need, rather than the ability to pay.*

[16] Department of Health 'Building the National Care Service' White Paper, March 2010, p.134 - http://collections.europarchive.org/tna/20100509080731/http://dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_114923.pdf

[17] Ibid., p.67.

Work in partnership *– with all the different organisations and people who support individuals with care and support needs day-to-day.*

Ensure choice and control *– valuing all, treating everyone with dignity, respecting an individual's human rights, personal to every individual's needs, and putting people in charge of their own lives.*

Support family, carers and community life *– recognising the vital contribution that families, carers and communities make in enabling people to realise their potential.*

Be accessible *– easy to understand, helping people make the right choices."*

If implemented, these proposals will undoubtedly remove a large part of the burden from informal carers in England, and in rest of the UK if the devolved administrations continue to adhere to the principal of parity.[18]

A review of support for carers in Northern Ireland was carried out in 2009 by the Department for Social Development (DSD) and the Department of Health, Social Services & Public Safety (DHSSPS).[19] The review resulted in the following recommendations:

- the long-standing policy of parity between Great Britain and Northern Ireland in social security should be maintained;
- the Minister should continue to liaise with the Secretary of State for Work and Pensions in relation to carers' issues and the Department should work closely with the Department for Work and Pensions on the reform of carers' benefits aspart of the process of welfare reform;
- the Social Security Agency should include an exercise on Carer's Allowance as part of its Benefit uptake programme;
- the Department for Social Development should work closely with the Department for Work and Pensions and with carers' organisations in examining the future role and scope of carers benefits;
- membership of the "Carers' Strategy Implementation Group" (CSIG) should be reviewed to make sure that there is representation at a sufficiently senior level from all Directorates within DHSSPS with responsibility for carers thus ensuring that the voice of carers is heard at Departmental Board level; all Commissioners & HSC Trusts and carers' representatives also should be represented on this Group. In addition, the ToR for this group should be amended to include a role in monitoring the implementation of the recommendations of this Review;

[18] The Scottish Government is currently developing a strategy for carers and it will be interesting to see what comes out of that (the report was due to be published by the end of June) - http://www.scotland.gov.uk/Topics/Health/care/Strategy/Carer

[19] DSD/DHSSPS 'Review of Support Provision for Carers', September 2009 - http://www.dhsspsni.gov.uk/review-of-support.pdf

- the person-centred Carer's Support and Needs Assessment component of the "Northern Ireland Single Assessment Tool" (NISAT) will be embedded in the process to assess the needs of carers in the Older People's Programme of Care by June 2010 and in parallel with this process, opportunities for its implementation in all other Programmes of Care should be exploited;
- Commissioners and HSC Trusts must use the "Trust Self Audit Tool" developed and issued by DHSSPS to report on and monitor progress towards the implementation of the recommendations of "Caring for Carers" (January 2006), "Promoting Partnerships in Caring" (December 2007), "Audit of Support Services for Carers" (June 2008) and reflected in actions required from Commissioners and HSC Trusts in Departmental Circulars (HSS (ECCU) 4/2006 & 3/2008) and reflected in standards issued by DHSSPS over this period;
- DHSSPS should request that the Regulation and Quality Improvement Authority (RQIA) include a thematic inspection of carers' issues in their work plan for 2011/2012;
- DHSSPS should produce and issue an up-to-date version of the "A-Z for Carers"by December 2009;
- DHSSPS in partnership with Commissioners and HSC Trusts should ensure that there is good quality information collected about carers particularly in relation to carers' assessments, respite care including unmet need and Direct Payments which can be utilised in planning for future service requirements;
- DHSSPS should engage with Commissioners and HSC Trusts to explore the potential for carers to receive better levels of training in the more technical aspects of their caring responsibilities;
- DHSSPS should ascertain what provision there is for breaks for carers (including emergency breaks) in Northern Ireland, assessment of level of need and the effectiveness of the models being used both in Northern Ireland and England, with a view to bidding for appropriate resources during the next CSR to allow investment in these important services;
- HSC Trusts should have in place procedures to provide emergency respite cover for carers; and carers should be made aware of the Trust's protocol for when these emergency provisions will be brought into play;
- DHSSPS should monitor the progress and outcome of the Department of Health's evaluation of the demonstrator sites testing: breaks for carers, better National Health Service (NHS) support for carers and health checks for carers; and
- DSD and DHSSPS should work more closely in terms of provision of information and signposting for carers.

The recommendation that parity should be maintained would suggest that Northern Ireland will be adopting the Department of Health's proposals for a new National Care Service after 2015.

6 Rate Relief and Carer's Allowance

The Committee for Finance and Personnel has been working with the Department of Finance and Personnel over recent months to determine how to give carers additional financial support. The Committee has asked the Minister to consider a number of options for providing support through further rate relief, including the possibility of increasing the carer premium element of the low income Rate Relief Scheme. The Minister has responded positively to the suggestions put forward by the Committee.[20]

The Rate Relief Scheme in Northern Ireland is designed to help those who are not getting full Housing Benefit on their rates charge. An assessment of Housing Benefit is first required to establish any entitlement to Rate Relief.[21]

Entitlement to Rate Relief is determined by comparing income to what is called an "applicable amount" - a weekly figure set by government for people to live on based on their particular circumstances. The difference between the two amounts is known as "excess income."

You have to pay 12% of your excess income towards any rates liability remaining after your entitlement to Housing Benefit has been calculated. Rate Relief will then cover any rates charge remaining after these calculations.

Some examples, given by the Housing Executive, are as follows:

- A family with two children and a weekly income of £278.53 and a weekly rates charge of £11.62 would receive Housing Benefit of £2.40 for rates and Rate Relief of £3.69.
- A lone parent with three children and a weekly income of £256.48 and a weekly rates charge of £13.31 would receive Housing Benefit of £6.21 for rates and Rate Relief of £2.83.

If a carer is receiving Carers Allowance or has an underlying entitlement to it, and is receiving Housing Benefit or Rate Relief, they will also qualify for a Carer Premium of up to £30.05 per week.

In view of the DSD/DHSSPS recommendation that parity with GB should be maintained and the proposed introduction of a new National Care Service by the Department of Health in England, it is not clear how the current Rate Relief Scheme in Northern Ireland might feature in any future system of support for carers. It may be worth

[20] See Committee for Finance and Personnel Press Release, 26 May 2010 - http://www.niassembly.gov.uk/finance/2007mandate/press/2009/FP070910.htm

[21] NI Housing Executive - http://www.nihe.gov.uk/index/yh-home/rate_relief.htm

examining the feasibility of providing further rate relief for carers, in the short term, in addition to the currently available rate relief and carer premium. However, it is likely that such an option would have to be reconsidered with the introduction of personal budgets and free personal care at home in England from 2011, and in light of the proposals for the new National Care Service after 2015.