

21st Century Social Care



What's wrong with social care and how we
can fix it

Warwick Lightfoot, Will Heaven and
Jos Henson Grič

Foreword by Jacob Rees-Mogg MP



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Contents

About the Authors	2
Acknowledgements	3
Foreword	5
Executive Summary	7
1. How the care market works: double standards	14
2. What are the problems?	32
3. How we can solve the problems: policy	52
4. How technology can help	60

Foreword

by Jacob Rees-Mogg MP

Every Member of Parliament will be aware of the deep unfairness inherent in this country's health and social care provision. We see it close up in our constituency work. Those with one type of illness – cancer, for example – are well looked after by the National Health Service. Medical care, from GP appointments to the operating theatre and into recovery, is free at the point of use and usually of a high standard, even if there is some room for improvement.

Constituents with more long-term conditions, however, are not so fortunate. An elderly person who suffers from dementia, for instance, and who requires long-term complex social care – either at home or in a residential setting – may have to pay tens of thousands of pounds, even hundreds of thousands, from their own capital and retirement income, until they are down to their last £23,250. The fruits of a lifetime of hard work and careful saving can be wiped out: there is certainly no reward for prudence here. The powerful bequest motive that guides behaviour among all conservative-minded people is effectively demolished.

Thankfully, the social care received will usually be of a good standard, even if underinvestment in the sector has taken its toll. But the impact on that person and their family, at a difficult time in their lives, can be devastating. It can involve the forced sale of the family home. The effects can be even more severe when a much younger person requires long-term care and finds the welfare state has turned its back on them.

Politically, it is by no means easy to fix this problem. We saw this in the 2017 General Election, when an untested and frankly disastrous policy was launched in the Conservative manifesto – the so-called “dementia tax”. It protected some assets, admittedly, but it highlighted and confirmed the huge sums people might be forced to spend on social care. There was no sense of pooled risk and a lottery remained for people requiring care, which depended entirely on the sort of illness or condition they faced. The public was not impressed and that was evident in the election result. Worryingly, it seemed as if social care had become a “third rail” in British politics: too dangerous to touch, which perhaps explains why the Government's long-awaited green paper on the subject has yet to surface.

For this reason, I am pleased that Policy Exchange, a centre-right think tank with a strong record of providing ideas for welfare reform, has explored such a vital policy area, which affects millions of people – including the children and relatives of those needing care. In *21st Century Social Care*, researchers – including one of Lord Lawson's former Special Advisers – have put forward recommendations that I find persuasive. This

is one area, it is clear, where the state has a significant role to play. It is far better to pool risk and for the taxpayer, where appropriate, to step in and help those who would face ruinous costs on their own, making social care largely free at the point of use. This is something we can afford as a nation, as Sir Andrew Dilnot and others have pointed out, if we can only get our priorities right.

Nonetheless, as a Conservative, I also applaud the idea of an affordably small co-payment, of the order of £5,000 per year, for those who need social care, so that they are treated more like consumers of a service and less like those who can only take what they are given by some beneficent state provider. It is also right that it is charged on income, not savings, and is only paid by those who can afford it – not, for instance, those whose retirement income is the state pension alone or not much more.

There are some who have argued for a new tax, used solely for the funding of social care – in other words, a hypothecated social care tax. This would be pure sophistry and should be avoided. In cyclical downturns in the economy, the amount raised by such a tax would fall. In that scenario, would it be right to slash social care provision? Of course not. Likewise, in periods of boom, there might be higher-than-expected revenues – and earmarked money, in the absence of a rise in demand for social care, might be wasted. Partial hypothecation, where the Government can top up the tax revenue or take some of it for other uses, is even more fraudulent: a lie told by those who believe the taxpayer is gullible. Far better, as Policy Exchange's paper sets out, to pay for social care out of general taxation like any other normal area of public expenditure.

The Conservative Party has a better record in the area of social care than recent history might suggest. For example, it was the Tories who introduced the Attendance Allowance in 1971, which is not means-tested and helps well over a million people today pay for personal care. But there is much more to do and for too long the issue has been kicked into the long grass. It is time for Conservative leaders to think differently, and radically. In another age, the original One Nation Tory, Benjamin Disraeli, sought to improve the “condition of the people”; in our own time, we should recognise that social care reform is one of the great challenges where the people need to see new political leadership.

Executive Summary

This research paper explores the nature and extent of the serious and urgent problems affecting the provision of social care in the UK.

It identifies how these problems have evolved from the institutional structures developed for providing health and social care and offers proposals for complex, long-term social care in England.

How we got here

- From its inception in 1948, the NHS provided tax-funded health care free at the point of use, while social care was the responsibility of local authorities that were required to make those in need of it pay if their assets exceeded a low cap through a strict social security-based means test. The result was that well-off people were entitled to have what were classified as medical conditions (cancer and heart disease, for example) paid for in full under the NHS. Meanwhile, far poorer people with chronic conditions and needs (such as Parkinson's disease, stroke recovery and dementia) were charged by their local authorities for social care until their modest assets fell below the relatively low level of the means test and its capital threshold.
- These separate charging regimes created a key impediment to effective coordination between the two services. The division of responsibilities between the NHS and local authorities compounds these difficulties to this day.
- Major public inquiries have sought to resolve these anomalies, but split responsibility, persistent underfunding, political timidity and the use of the issue as a political football have impeded reforms and left fundamental problems unaddressed. There has been a neglect of social care compared with other clinical and medical services. Having local authorities funded by government to take the lead in long-term community-based social care created a disconnection between those providing funding and those delivering social care, with the former having the power to impose an effective cap on social care provided in the community.
- While most people know how to access the NHS, securing social care is a labyrinthine process that few people fully understand. To compound this, there are different funding arrangements in the four nations of the United Kingdom. This paper makes proposals for England but explores them in the wider context and experience

of the way policy has developed in the devolved nations.

- Social care funding has been significantly constrained since the 1990s. The frustrations of dealing with a convoluted bureaucratic process have increased, as local authorities cope with shrinking budgets and increased costs.
- The UK's lack of generosity towards older households is evident in international comparisons. Our expenditure on health and social care is noticeably below the OECD average,¹ and our state pension is markedly lower than those in other advanced economies.²
- 410,000 residents live in 11,300 care homes operated by 5,500 providers in the UK, with around 95 per cent of beds provided by the independent sector.³ As local authorities have increasingly exploited their bulk purchasing power to drive prices below the cost of providing the care, the sector is gradually directing new investment towards the self-funders. They subsidise the places bought for people by local authorities and pay on average 41%⁴ more per place. Given consistently compressed funding and increasing staff costs, there is serious concern about the future viability of the sector.

What are the key problems?

In common with other advanced societies, the UK faces a serious demographic challenge. In 1991, 15.8% of the UK population was over 65: by 2016 this had risen to 18% and by 2030 is likely to be over 22%.⁵ As the number of old people grows, and funding has been constrained in relation to need, and in recent years has even fallen, resources have to be spread more thinly, yet more people have conditions requiring complex and serious social care.

The main problems affecting the care sector are:

- Its unworkable structure
- Its economic unsustainability
- Its deep unfairness

The unworkable structure

- The fact that social care remains the responsibility of local authorities means that ensuring consistent working between hospitals, general practitioners, and social service teams presents an almost insuperable challenge: the differences in funding and charging are key obstacles to achieving effective coordination.
- Decades of initiatives to promote collaborative working between local authority social service departments have been very disappointing in their practical results.

1. OECD, Health Expenditure and Financing, long-term care (health), <https://stats.oecd.org/Index.aspx?DataSetCode=SHA>

2. OECD, Pensions at a Glance 2017: How does the United Kingdom compare?, 5 December 2017, <http://www.oecd.org/unitedkingdom/PAG2017-GBR.pdf>

3. Competition & Markets Authority, Care homes market study: summary of final report, 30 November 2017, <https://www.gov.uk/government/publications/care-homes-market-study-summary-of-final-report/care-homes-market-study-summary-of-final-report>

4. CMA, Care home market study: final report, 30 November 2017, p14, <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf>

5. <http://obr.uk/forecasts-in-depth/brief-guides-and-explainers/an-obr-guide-to-welfare-spending/>

The economic unsustainability

- The underfunding of care, the uncertainty about future funding, and the fact that much of the present care provided is available only through the differential pricing regime that penalises self-funders means that care providers are reluctant to engage in new investment to accommodate those paid for by local authorities.
- Crucially, those authorities cannot offer effective incentives to encourage care companies to invest in providing the service in their communities.
- The sector is highly fragmented, with 80% of care home providers operating a single home and accounting for 29% of beds.⁶ However, economies of scale do not offer what people want: while larger homes are more economically viable in the long term, the Care Quality Commission rates small nursing and residential homes as offering significantly better standards of care. The same applies to domiciliary care services.⁷
- During the years of funding reductions, increasing costs and the shunting of the financial burden on to the self-funders, the public sector failed to invest the necessary resources even to fund that part of the care system it directly commissions itself, yet demand for social care rises steadily, even as spending has been constrained.

The deep unfairness

- The distorted priorities of the NHS since its foundation – which exhibit a bias in favour of treating acute conditions, along with neglect of community medicine, palliative care and other help for the chronically ill, the old and the dying – have been compounded by the incompatible bureaucracies and charging systems. The Competition and Markets Authority identified self-funders as being the big losers, paying on average £44,000 annually from post-tax income, far higher than the fees paid by local authorities buying places in the same home. The great majority of self-funders are not wealthy: practically anyone who owns their own home is ineligible for state funding. They are subsidising a system that is fundamentally unfair.
- The challenges that families face are not confined to the caricature of a very elderly person towards the end of their life needing care but can pose acute problems for families where a younger person in middle age or even earlier experiences early onset dementia, Parkinson's disease or a stroke.
- There is a perception that older households have been exceptionally generously treated in the United Kingdom by the tax and benefits system in the last 40 years. This represents a misleading gloss on a complicated evolution of measures that have shifted resources from older households and households preparing for retirement towards

6. <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf>

7. CQC, The state of adult social care services: 2014 to 2017, p19, https://www.cqc.org.uk/sites/default/files/20170703_ASC_end_of_programme_FINAL2.pdf

households with children. For many years, the basic state pension was indexed only for prices, the state second pension (formerly known as SERPS) was significantly eroded, the complex tax credit on dividends received by occupational and personal pensions was abolished in two stages in the 1990s and the retirement age for men and women has been equalised and is now being increased. As well as this, in relation to social care, the Community Care Act 1990 effectively capped the amount of public money going into long-term social care and the eligibility criteria used when making assessments for care have been progressively tightened.

The aim of a 21st century social care system

- We need to ensure that the health and social care systems are both adequately funded and in a coherent manner with as much consistency as possible between a social care system with an element of means-testing and a health service that is free at the point of use.
- This means that the present, very stringent means-testing regime should be significantly modified and made much more generous from the perspective of the user of the service.
- This would achieve much greater coherence, efficiency and confidence that will help to ensure a balance of demand and supply and give the care industry the confidence to invest to raise quality and productivity.
- Similarly to health care, complex long-term social care needs to be largely free at the point of use and principally funded through general taxation.
- With a more financially integrated system, there will be scope for significant savings for the NHS, which has constant problems with thousands of patients being trapped in hospital for lack of social care.
- The costs are affordable. Total public expenditure currently accounts for about 38% of GDP, of which health absorbs 7.5%, the state pension 4.5% and social care 1%. The proposal fully to fund complex long-term social care would involve additional spending of some £11bn, or around 0.5% of GDP, equivalent to 1.3% of total public spending.⁸
- The increased spending to ensure that social care and health care can be funded in a way that makes the services more coherent is affordable in relation to overall public expenditure and the size of the economy. The decision to do it or not essentially turns on relative spending priorities. Sir Andrew Dilnot has expressed the matter cogently: “There’s plenty of money... GDP in real terms is more than 5.5 times as big as it was in 1948... We may choose not to afford it but the notion that we can’t afford something, given what has happened to our income, is striking and quite surprising,

8. Based on a National Audit Office (NAO) estimate of the amounts spent privately on care: NAO, Adult social care at a glance, July 2018, p10. <https://www.nao.org.uk/wp-content/uploads/2018/07/Adult-social-care-at-a-glance.pdf>

and doesn't strike me as correct.”

- All public spending involves a real resource cost which, given the deadweight effects of spending, is greater than the cash amounts involved. These proposals in relation to social care are manageable within evolving public spending priorities and address an area where conventional markets do not work for households at a manageable cost – and can involve bankrupting a household.
- Long-term projections of costs within national income in the context of an ageing population are always difficult to make. The UK does have an increasingly elderly population but that older population will be financed and managed in the context of a steadily growing level of GDP which means that these costs will remain manageable.
- Spending on social care should be funded principally through general taxation. A hypothecated tax serves little practical purpose. Although hypothecation can be superficially attractive in presentational terms, the flaw is that the assigned revenue may yield receipts that are too little to pay for the programme or exceed any sensible estimate of its cost in terms of conventional notions of economy, efficiency and effectiveness.

How technology can help

- Though they cannot cure the underlying problems, technological innovations can alleviate them. There is still a long way to go, but in recent years the NHS has made some progress in terms of driving forward its digital transformation plans and embracing technology.
- The rapid pace of innovation seen in areas like AI – where diagnostic chatbots can now outperform human physicians – or in the coordination and improvements in the quality of domiciliary care services through the use of cloud-computing and remote monitoring of patients, show that there is some potential to improve the quality of care, choices and efficiency.
- The Government should explore ways in which the NHS can be given greater autonomy over how it uses and influences the development of HealthTech innovations.
- The NHS can also improve social care, in terms of providing greater clarity, control and patient choice, in a way that fits within the Government's Digital Transformation Strategy, led by the Government Digital Service, which created the award-winning Gov.uk platform as a simple online portal for people to access public services.
- Tools that would make a great deal of difference could include a “MySocialCare” app for assessing the care needs and relative priorities patients themselves have. Such tools obviously cannot

replace the role local authorities have in carrying out the assessment process for personalised care, but they can aid them.

Summary of recommendations

- To achieve the greater coherence, efficiency and confidence that will ensure a properly functioning social care system, complex long-term social care should be funded through taxation as part of public expenditure. Like any other health or public spending, social care should be financed principally out of general taxation.
- By ‘complex long-term social care’ we mean care required as a result of serious, chronic, long-term conditions which render it impossible for a person to function normally without extensive care, which has the potential to bankrupt a household should it be exposed to the full costs of the care. It is recommended that only this type of care should be principally funded as part of public expenditure.
- Like health care, complex long-term social care in England should be available on the basis of need – largely free at the point of delivery.
- The present income and capital means test for complex social care should be ended. The capital component of the test should be eliminated and the means-tested charging regime should be changed into a limited co-payment regime of the order of £5,000 per person per year means-tested on income. **The new co-payment regime should be constructed so that no present user pays more than they pay under the current means-testing arrangements** and all users of the service face a co-payment no greater than £5,000. This would not preclude additional private payments for extra services.
- As a basis for consultation, the starting point for the co-payment should be around one and a half times average annual pensioner income which is approximately £27,000.⁹
- This proposal would mean that care would be largely freely provided in people’s own homes, in residential care settings such as care homes and nursing homes and it would include what are described as “hotel costs”.
- There should be a review of the assessment criteria and the thresholds of need for care to ensure that there is consistency of provision across the country. It is the framework of assessment that will ensure that the costs of care are contained in an affordable way.
- There should be additional funding in the Government’s comprehensive spending reviews to remedy the long-standing neglect of social care that is gradually making the sector unviable.
- The institutional relationship between health and social care should be reviewed to assess whether social care should remain the

9. Based on median weekly net income before housing costs in 2017/18, which was £344, DWP, ‘Pensioners’ income series: financial year 2017 to 2018, Table 2.1, <https://www.gov.uk/government/statistics/pensioners-incomes-series-financial-year-2017-to-2018>

responsibility of local authorities, given their other responsibilities and the changes being made to the local authority grant regime.

- As part of an emphasis on improving the dignity of older, frail and disabled people, more importance should be given to respecting their autonomy, priorities and choices. The principal purpose of the co-payment is to stimulate their role as consumers of the service and to invigorate the ideas that have informed the development of personal budgets. It is not intended as a mechanism for recovery of the economic cost of the service.
- The NHS should be encouraged to work with the UK's HealthTech sector, in areas like AI and robotics that could lead to improvements in the delivery of social care.
- Policymakers in England and across the UK should be attentive to examples of developing use of technology in countries such as Japan and Norway and in any other countries where innovation is identified.
- For example, remote patient monitoring and quicker assessment of crisis situations are two challenges with the most potential to be addressed through technology, including wearable devices. The government should take ambitious steps towards assessing the potential for making greater use of such technology.
- NHS Digital should examine with the Government Digital Service the potential of creating an interactive "My Social Care" app that can be used by patients and families to access information about care options.

1. How the care market works: double standards

Introduction

Going with the grain

This report starts from the premise that in a modern economy government should provide classical public goods, such as defence, merit goods such as education and research, and transfer payments to modify the uneven dispersion of income, goods and services that are disproportionately expensive for households to finance. Within the continuum of health and social care, the UK already pools risk across the community collectively in the NHS, yet the rules are different for social care. Not only is the sector failing to do a good job: it is in crisis because of its inherent weakness.

The UK is unusual in that – with a few exceptions such as prescriptions, dentistry and sight tests – the state plans, finances and provides health care without charge. This applies even in areas such as consultations with primary care physicians and specialists or straightforward surgery such as hip replacement where in principle insurance markets could play a limited role, although it is a change from the present health service that this report does not suggest.

The National Health Service (NHS) was created in 1948 by a Labour government that effectively nationalised the provision of health care with the creation of a comprehensive tax-funded system free at the point of delivery. It owns, manages, and regulates centrally the hospitals that along with general practitioners (GPs) are the principal providers of care. Despite imperfections that include periodic crises and poor information technology, it works well and commands widespread affection and trust throughout the United Kingdom. It was no surprise that the opening ceremony of the 2012 London Olympics celebrated the NHS as “the institution which more than any other unites our nation”.¹⁰

Unlike systems of social insurance developed in advanced economies in western Europe in the 1950s and 1960s, it was devised to have little or no co-payment. As the King’s Fund note in their comparative review, “the NHS is unique in its low level of cost sharing”.¹¹

Both Labour and Conservative politicians have at times explored insurance systems of the kind that are common in Europe, but this approach has never gained popular support. This report will not be challenging that well-established and popular fundamental NHS model of a tax-funded system.

10. Olympic programme <http://www.msnbc.com/msnbc/british-celebrate-national-health-care-i>

11. King’s Fund, *The Social Care and Health Systems of Nine Countries*, pp. 9

The birth of Cinderella

Our concern here is social care, which was also addressed in 1948. Although run by local authorities, was intended to dovetail with the NHS, but in reality has an uneasy relationship with it. This Cinderella has developed piecemeal, varies across the UK, is difficult to understand and access, has been persistently underfunded, provides a variable standard of care, is perceived as unfair, causes widespread worry and anxiety among the vulnerable and can bring disaster to the unlucky.

The 1948 decisions that resulted in excluding social care from the service financed by the state have led to a fundamentally incoherent system and a series of perverse consequences for individuals and the NHS. Medical conditions even of a relatively minor character are covered freely without charge, while many people who require serious social care as a result of illness or frailty have to pay significant costs for it. Individuals with different conditions resulting in similarly debilitating suffering and frailty are treated in wholly different ways according to what seem like arbitrary criteria. Separate charging regimes for health and social care are a central impediment to effective co-ordination between the two services, and the fact that social care remains the responsibility of local authorities compounds the difficulties.

And while co-payments are anathema to the NHS, they are integral to social care, given that local authorities fund only low-income individuals. With an ageing society, cuts to local authority funding, increased costs, the lack of cooperation that come from unaligned health and social care, and the unfairness of a system that penalises people for saving for retirement, governments have addressed public unease by commissioning major public inquiries, but most of these (with the exception of the Griffiths report) have been set aside as flawed, too difficult or expensive to implement.

The purpose of this report is to identify the major problems and suggest long-term solutions that could be accepted across the political divide.

Social care glossary

Care Needs Assessment	An opportunity for a social care professional to assess an individual's needs to identify what level of social care provision they require. Local councils have their own assessment procedures but follow national criteria to decide who is eligible for care, and on what scale.
Capital Test	A test through which the government assesses an individual's ability to pay for their own social care, based on their financial means, both through incomes and assets.
Care Act 2014	An Act of Parliament that set out local authorities' duties in assessing an individual's needs, and their eligibility and right to provision of social care.
CMA	Competition and Markets Authority: a non-ministerial government department that encourages business competitiveness and seeks to prevent anti-competitive or illicit behaviour.

Social care glossary	
Co-payment	A relatively small fixed fee that a health insurer requires the patient to pay upon incurring a medical expense (e.g. a routine office visit, surgical procedure, or prescription drug) covered by the insurer
CQC	The Care Quality Commission, the independent regulator of health and social care in England
Domiciliary Care	Provided for individuals who continue to live in their homes, but require from a paid helper personal care or other assistance such as clinical care, medication, help with household tasks and meal preparation.
Eligibility Criteria	The measures through which a local authority decides whether an individual qualifies for the provision of social care, and at what cost.
Hotel Costs	The normal costs of daily living for an individual in a care home, including food, energy bills and accommodation costs. Caps on social care costs do not usually factor in these costs.
LA	Local Authority
Local Authority	A county council, a district council if no county council exists, a London Borough Council or the Common Council of the City of London.
NAO	National Audit Office
NICE	National Institute for Health and Care Excellence
OBR	Office for Budget Responsibility
OECD	Organisation for Economic Co-operation and Development
ONS	Office for National Statistics
Personal care	Assistance provided through social care when an individual requires personal assistance with issues including, for instance, dressing, feeding, washing, toileting; emotional or psychological support.
Reablement	Services for people with poor physical or mental health to help them deal with their illness by learning or re-learning the skills necessary for daily living.
Residential care	Care provided to individuals in a residential setting rather than in their own home, or the home of a family member. These residential settings usually provide a personalised care service to small groups of adults including lodging, food and assistance with daily tasks.
Self-Funder	Anyone who pays the full cost for their own provision of social care.
Social Care	Social Care is the provision of social work, personal care, protection or support services to individuals who are in need or at risk. This can be caused by a variety of factors including illness, disability, old age or poverty.

Social care glossary

Social Care Market	The social care market refers to the wide range of private and public sector providers as well as families and communities that deliver the provision of social care.
Social Security	Any governmental system that provides monetary assistance to people without adequate income. This includes the provision of social care to those without substantial assets.
Well-Being	The Government determines an individual's "well-being" as related to the following: personal dignity; physical and mental health; control over everyday life; participation in society; social and economic status; personal relationships; living situation; and contribution to society.

'Everybody's distant cousin but nobody's baby'

The major public inquiries referred to above reflected the growing significance of social care in an ageing society, a determination to accelerate the process of caring for people in the community rather than in institutions, and the increasing challenges that arise from a system of health care and social care that cannot cohere because of the fundamental differences that arise from their financial and management structures.

Community care in theory

Most influential was Sir Roy Griffiths' 1988 report *Community Care: Agenda for Action*. He had the great advantage of having written in the early 1980s an inquiry into NHS management: although he was a great admirer of the institution, he was a critical friend. He addressed particularly the perverse incentive that local authority social service departments had to place people who just needed domiciliary care into residential care homes so they were funded by the social security budget rather than the council. In this report he identified the overlapping responsibilities that the NHS, local authorities and social services had for care and vividly described it as "everybody's distant cousin but nobody's baby".

He recommended that:

- local authorities should take the lead in the provision of long-term community-based social care, be supported by a specific grant from central government to do so, and be responsible for assessing local and individual care needs
- local authorities should have a commissioning role to enable them to promote the use of the independent sector, collaborating with the voluntary sector and private-sector providers
- social services departments should have responsibility for the registration and inspection of all residential homes, whether run by private organisations or by the local authority

The principal recommendations were accepted and enshrined in the

National Health Service and Community Care Act 1990 (henceforth referred to as the Community Care Act 1990). The inference from the Griffiths report was that the state was to be an enabler of care rather than a direct provider and the roles of purchaser and provider of services were separated, reflecting wider changes being made at that time as part of the introduction of an internal market into the NHS. Key recommendations ignored in the legislation were the appointment of a Minister for Community Care, earmarked funds for social care and the placing of community nursing staff under the control of local authorities rather than Health Boards.

The legislation transferred to local councils the money spent by social services through the housing benefit budget to pay for people in private and voluntary residential and nursing homes. After the Community Care Act 1990, an inspection regime to publicly provided residential care settings was applied for the first time. The quality of care and facilities provided in the homes managed by the private and voluntary sectors was often better than in those provided by local councils or the NHS and often the changes necessary to make public-sector-run homes compliant with inspection standards would have been expensive and involved extensive capital spending. This presented a difficulty for local authorities because of the rules rationing their access to borrowing and making use of asset sales that meant that for most councils money for capital investment was usually limited and had many competing claims.

Community care in practice

In practice this meant that councils increasingly placed people needing residential and nursing home care in homes run by the private and voluntary sectors. Given the tight public expenditure settlements in relation to care – where the Treasury used the ring-fenced social care budget as an opportunity to constrain social care spending – councils increasingly used their leverage as monopsony¹² purchasers to drive their unit costs down until they were way below the cost of provision. Social care after 1990 was increasingly delivered in a distorted market where nationally imposed regulation and ambitious care standards pushed up costs, while the public sector's spending was squeezed. Whether a service is delivered through direct provision or purchased from the private sector, it cannot be sustained if resources are insufficient and wages and other costs are driven below the level they would be set by normal notions of opportunity cost and Pareto optimality.¹³

Capping spending

Until 1993, social services had been able to use the social security budget as a kind of safety valve to evade the problems that would otherwise have arisen from the constraints on their own budgets. But the Community Care Act 1990, which took effect three years later, enabled the imposition of a cap on spending on social care – effectively empowering local government and emasculating it at the same time. Instead of what had been essentially a

12. A market structure in which a single buyer substantially controls the market

13. A concept named after economist Vilfredo Pareto, this posits a state of allocation of resources from which it is impossible to reallocate so as to make any one individual or preference criterion better off without making at least one individual or preference criterion worse off.

demand-led programme, the Treasury and the Department of Health could now limit what was spent on long-term care through rationing access by tightening criteria. Increasingly, local authorities raised the threshold of need before care was offered, until few councils offered it to people with moderate needs.

Councils also responded to further national policy guidance to levy charges on individuals by maximising their income from what became known as “self-funders”. While local authorities had the statutory duty to assess their need for care, they fully charged for what was provided, often even refused help with navigating the system, and used their block purchasing power to reduce what they paid the homes, thus raising the pricing for the self-funders.

The result was growing public pressure on political parties in the mid-1990s to examine the funding of social care in general and long-term residential care in particular. By the mid 1990s quality, costs and who paid for social care were live and awkward political issues that led to a manifesto commitment from the Labour Party to set up a royal commission to look at the funding of long-term care as a whole. Long-term care arrangements were so unsatisfactory, said the then health secretary, Frank Dobson, that they “cannot be allowed to continue for much longer”.¹⁴

The Sutherland report

Sir Stewart Sutherland chaired the royal commission, which had bi-partisan support. The main conclusions of its 1999 report were:

- health and social care budgets should be merged to give the opportunity to rethink and reshape priorities in line with the ageing population
- the state should improve provision but it could not meet all the costs of long-term care in the broad sense
- the costs of “personal care” should be met by the state at an annual cost of between £800 million and £1.2 billion a year (between £1.2 billion and £1.8 billion at 2017 prices).¹⁵
- “hotel costs” – effectively food and the cost of the room – should continue to be met from people’s income and savings, subject to means-testing

Sir Stewart resisted government pressure to propose an insurance-based system, but a dissenting minority report – which opposed alleviating the cost burden on self-funders on the grounds that it would increase demand and remove the incentive to save – made it easier for the New Labour government to set aside the recommendations, which were also ignored by its successors. (In Scotland, however, the devolved Labour-Liberal administration broadly implemented them. The changes were popular but expensive.¹⁶) In 2009, Sir Stewart said that his “biggest disappointment” had been “that the government, when it rejected our proposals, didn’t come up with an alternative. If it had a better scheme, then we have not

14. <https://www.theguardian.com/society/2009/feb/25/interview-stewart-sutherland>

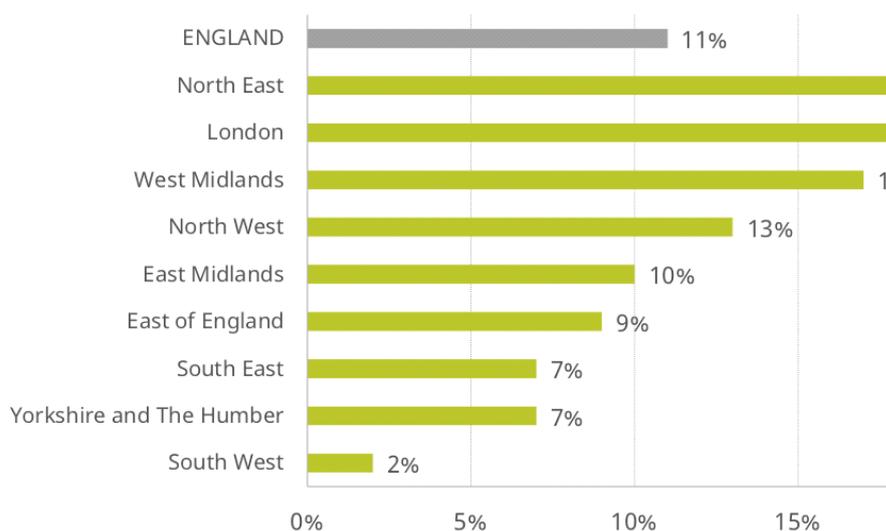
15. Using GDP deflator

16. <https://www.health.org.uk/newsletter/free-personal-care-what-scottish-approach-social-care-would-cost-england>

seen it. We are still at sixes and sevens.”¹⁷

The Sutherland Report, published in 1999, is now 20 years old and subsequent developments in life expectancy and the increased incidence of dementia have intensified pressures on social care resources. The Institute for Fiscal Studies has concluded that local authority spending on adult social care in England fell 8% in real terms between 2009–10 and 2016–17.¹⁸ Cuts have also been larger on average in areas with higher social-care spending needs as a result of changes to local government funding over this period. High-needs areas typically got more of their funding from central government grants (as opposed to council tax), so faced larger cuts to their total budget over this period.¹⁹

Average cut to local-authority-organised adult social care spending per adult by region, 2009-10 to 2015-16



Source: Table 4.1 of D. Phillips and P Simpson, National Standards, Local Risks: The Geography of Local Authority Funded Social Care, 2009-10 to 2015-16, IFS Report 128, 2017, <https://ifs.org.uk/publications/9122>.

“Death” and “dementia” taxes and the Dilnot Inquiry

Both major parties have struggled to find ways of resolving the unfairness of the system, while being themselves guilty when it suited them of treating well-meaning proposals for badly-needed reform as a political football.

In 2010, Labour’s suggestions for widening the range of estates liable for inheritance tax to raise additional revenue to fund increased spending on a National Care Service was opposed by the Conservatives as a “death tax”.

Subsequently, the Coalition government responded to growing media criticism of the means-testing regime by setting up an independent commission chaired by Sir Andrew Dilnot, which sought to eliminate the catastrophic costs faced by some people, capping the maximum amount that individuals pay over their life time and raising the capital test to

17. <https://www.theguardian.com/society/2009/feb/25/interview-stewart-sutherland>

18. The impact of cuts to social care spending on the use of Accident and Emergency departments in England <https://www.ifs.org.uk/uploads/publications/wps/WP201815.pdf>

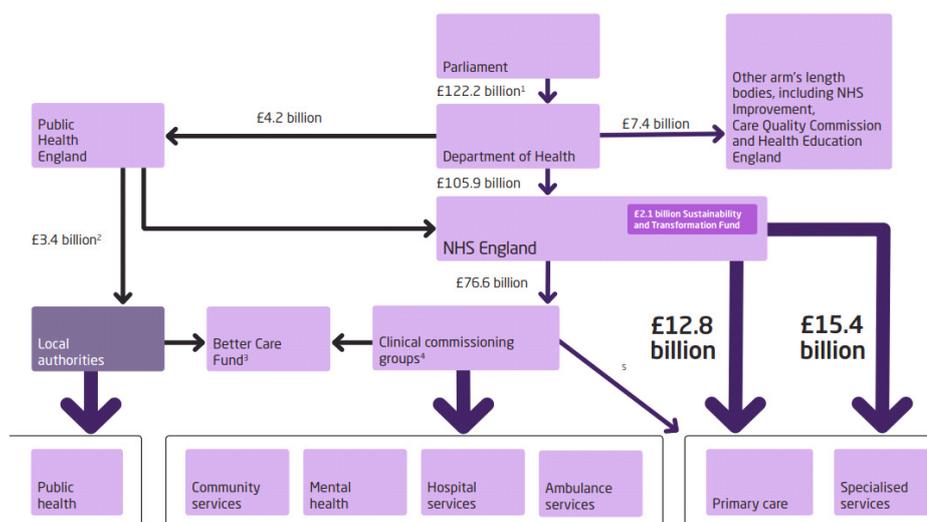
19. Public spending on adult social care in England: <https://www.ifs.org.uk/uploads/publications/bns/BN200.pdf>

£100,000, with state funding making up the difference. The purpose of this was to enable an insurance market to develop, but since insurance markets will not risk the costs of chronic conditions requiring long-term care, as explored in this report, there was widespread scepticism.

In response, in the Care Act 2014, the government introduced a cap of £72,000 on the care costs an individual would pay and raised the capital threshold to £118,000, but after the 2015 General Election the Conservative Government postponed these changes until 2020. This was scuppered when the 2017 party manifesto set out proposals to increase the capital threshold to £100,000: in effect this extended the means test to people receiving care in their own home by applying delayed charges to their house. During the contentious debate that followed, *The Spectator* described this as a “dementia tax”²⁰ and the phrase was taken up by the Labour Party, causing a Conservative U-turn and the promise of a green paper. The green paper was expected to be delivered before Christmas 2018, according to the Secretary of State for Health and Social Care, Matt Hancock. The department had difficulty in meeting previous ambitions to complete this work and has yet to publish the green paper.

The NHS and social care

The NHS: How the money flows



The King's Fund

A complicating factor that distorts and makes the provision of social care awkward is the complex relationship between the National Health Service and local authority provided social services. The NHS system has often been described as a command and control framework, analogous to the management regimes developed for running socialist countries with planned economies. In a reflection of the UK's ethos, there have been many limits that have in practice constrained its application. Even before there were any attempts to introduce elements of competition with free-

20. <https://blogs.spectator.co.uk/2017/05/tory-dementia-tax-backfire-theresa-may/>

standing hospital trusts, effective tools to control and command appeared in practice to many health ministers to be quite blunt.

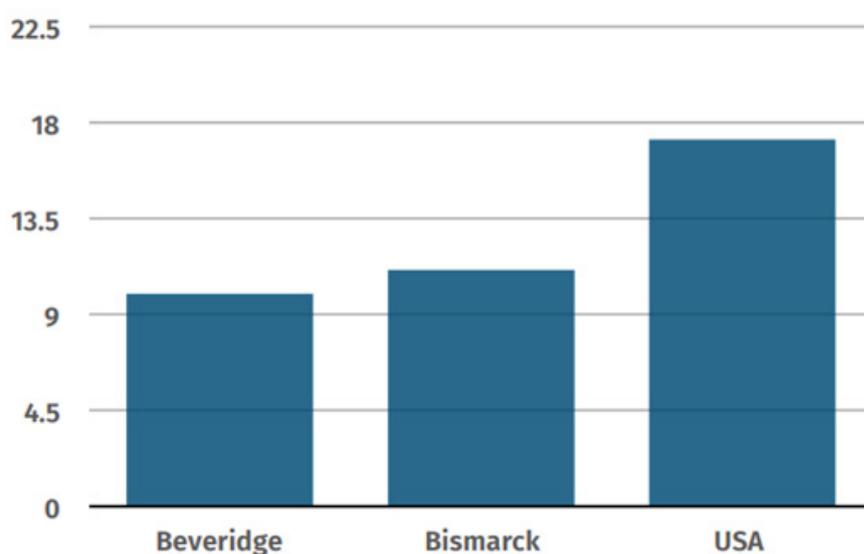
Also, the combination of the continuing dominance of hospital consultants, an overwhelming emphasis on acute medicine and the evolution of the district general hospital model, has helped bring about the relative neglect of chronic medical conditions and social care.

Controlling costs through care rationing

The command and control approach has been recognised by the OECD as an effective means of controlling overall costs by rationing the NHS's provision and controlling the costs through GPs – who act as gatekeepers – and by waiting lists. Priority within hospitals is given to people with the greatest clinical need.

In the 21st century, a growing realisation that general well-being should be a major objective led successive governments to devise plans to change priorities. In a report for the Institute for Public Policy Research, Lord Darzi notes that tax-based publicly provided health care systems – which he calls 'Beveridge' systems and contrasts them to continental 'Bismarck' systems based on social insurance – are 'less expensive than both private insurance systems and social insurance models'.²¹

Beveridge systems are consistently cheaper than their competitors

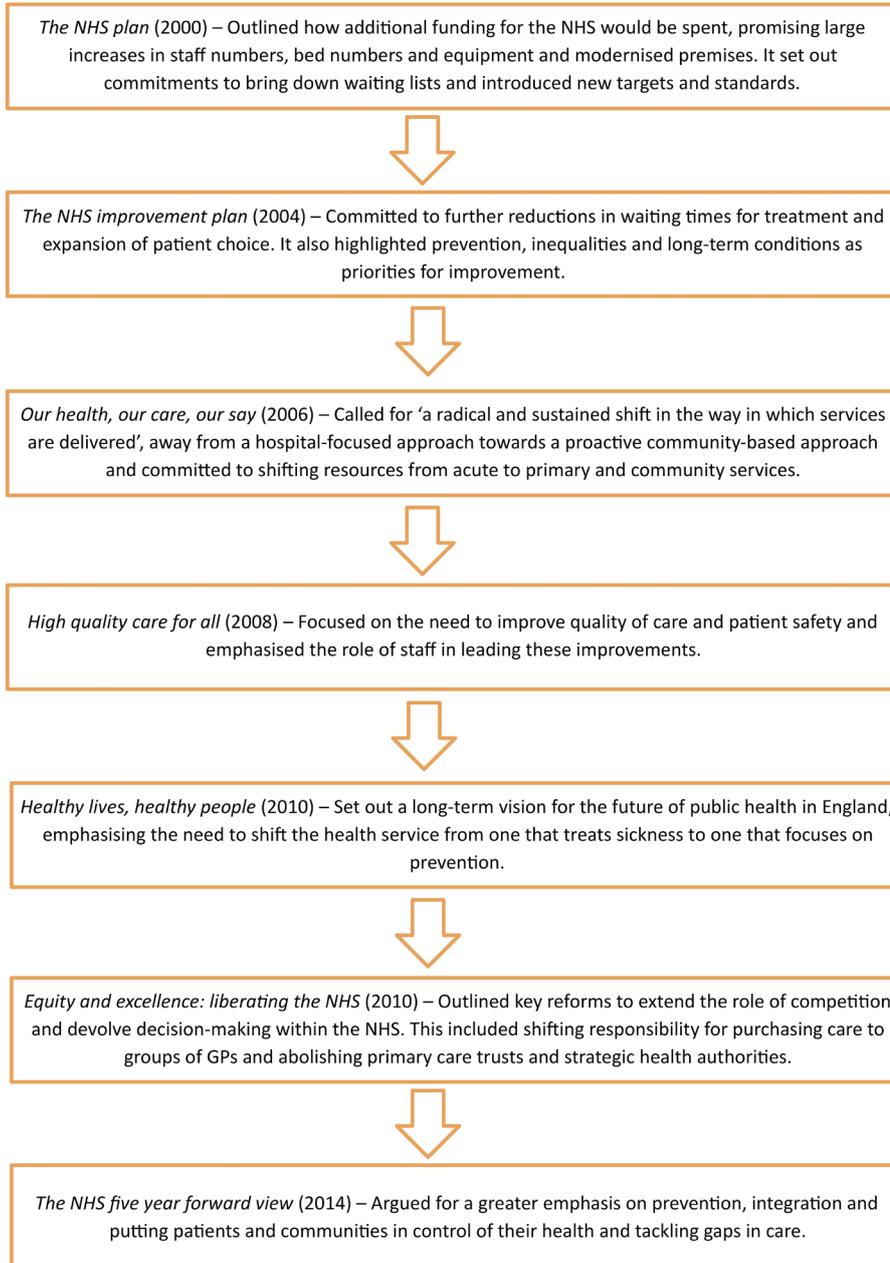


Beveridge and Bismarck Systems, health spend percentage of GDP, 2016. Source: Authors' [Lord Darzi's] own calculations, IPPR²²

21. <https://www.ippr.org/files/2018-06/better-health-and-care-for-all-june2018.pdf> pp. 71

22. <https://www.ippr.org/files/2018-05/lord-darzi-review-interim-report.pdf> pp. 33

NHS strategies 2000 - 2014



Over many years there have been several attempts to try to ensure that care provided by the National Health Service coheres efficiently with care provided by local authority social services departments. Despite an enormous amount of institutional and bureaucratic effort, the results have remained disappointing. Different organisations with different budgets working under different policy guidance have found it difficult to work effectively in a joined-up manner. A significant point at the heart of this difficulty is that care provided through the National Health Service is free of charge, while care provided by local authorities is subject to a strict means test, which can lead to extremely high costs for the individual.

While some of the initiatives outlined above that emphasise better co-

ordination between hospital services and community based services have been worthy attempts to improve the practical working between hospitals and social services departments, they are insufficient to overcome the root cause of the problem –the incoherent funding regime. Social care professionals have had reservations about locating the provision of social care within the health service because the acute sector tends to absorb a disproportionate share of the resources. However, due to the evolving functions of local authorities and the proposed changes to the grant regime, the Government should now review the question of where social care should be institutionally located in the future.

Getting through the labyrinth

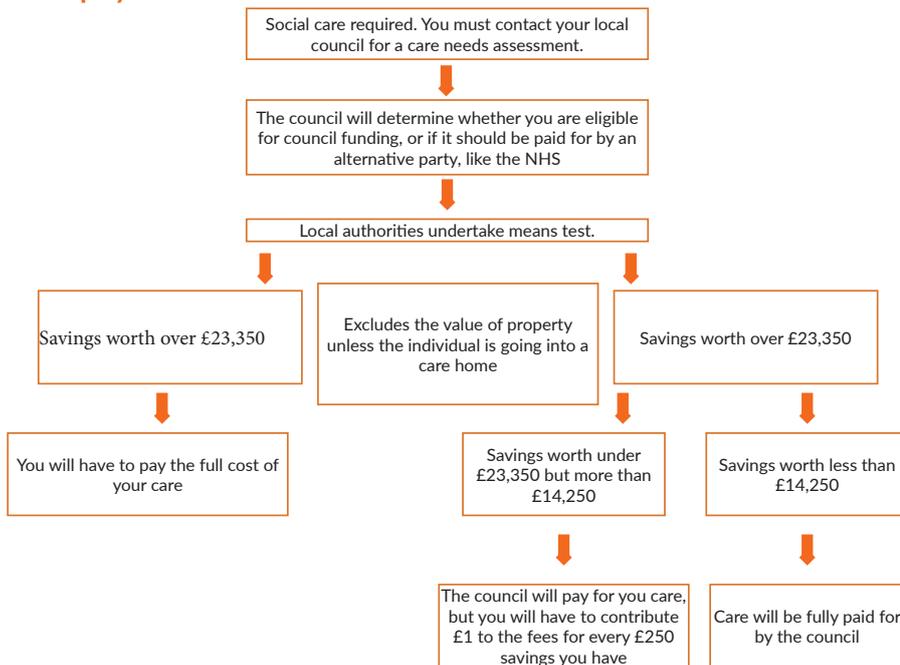
While most people know how to access the NHS, few members of the public other than those with personal experience know what to expect when social care is needed. Many people, because of age or infirmity, come to need care at home. Others, after a serious operation, a bad fall or a stroke might need temporary residential care. And others again need complex care permanently. This report's main recommendations concern those who need complex long-term social care, whether at home or in a residential setting.

Access involves seeking help from an often labyrinthine, slow-moving, and over-stretched system. Under the Care Act 2014 the first step is the local council. (The following figures relate to England.) Local authorities provide care for people needing social care. They have an obligation to make an assessment of the person's needs and frame a care package for them if their needs meet the criterion of the care assessment. Some 75 per cent of people who receive social care services obtain that support in their own home. This accounts for some 48 per cent of total expenditure on short and long term care services arranged by local authorities.²² Local authorities spend more on care homes for older people, however, than any other type of social care service.

The first challenge for any care arranged for people needing the service is for it to be respectful of their dignity and autonomy. The difficulty of going through assessments and seeking out information about entitlement can be burdensome. A key advantage of our proposal is the significant lightening of that burden. The removal of capital and assets from the means test makes it much simpler, while the modest co-payment means reduced costs for individuals who are above the requisite threshold.

23. NAO, Adult social care at a glance, July 2018, p14, <https://www.nao.org.uk/wp-content/uploads/2018/07/Adult-social-care-at-a-glance.pdf>

Who pays for care?



In the case of domiciliary care – social care at home – the means test is not applied to the home’s capital value, but all other financial assets (cash, equities, bonds and income) are taken into account. When a person is assessed as needing residential care, then all assets including the home are taken into the account. In practice, in many instances local authorities require self-funders to organise as well as pay for their own care.

There is a further complication. Funding arrangements differ in the devolved areas of the United Kingdom. Currently, Scotland supports long-term care more generously than other parts of the UK.

	Upper Limit	Lower Limit
England	£23,250	£14,250
Scotland	£28,000	£17,500
Wales	£40,000 (residential care) £24,000 (non-residential care)	n/a
Northern Ireland	£23,250	£14,250

Northern Ireland

In Northern Ireland, five health and social care trusts assess what help people need. For those over the age of 75, most domiciliary care is provided free, whereas those under 75 may have to pay towards it. Any charges are at the discretion of the local trust. If someone needs to be looked after in a care home or nursing home, those with assets of over £23,250 (savings, investments and property including the value of your home), pay for the full cost of their care.²⁴

24. <https://www.nidirect.gov.uk/articles/your-home-your-assets-and-your-residential-care-or-nursing-home-fees>

Scotland

In Scotland, people over 65 receive free personal care if assessed by their local authority as needing help. All care requiring a nurse is provided by the NHS. If an individual is in a care or nursing home, they will get £171 per week towards personal care and £78 per week towards their nursing care if they have a medical need.²⁵

In addition, if their assets fall below £28,000 (as of April 2019), they will receive further support for care. The lower limit was £17,500 as of April 2019.²⁶

Wales

In April 2018, the Welsh government increased the capital limit from £24,000 to £40,000 with appropriate increases in government funding.²⁷

Funding for England

For England, the best estimate available for total spending on social care arranged by local authorities in 2016-17 – both in care homes and in the community – is £20.4 billion.²⁸ That includes:

- £14.8 billion net spending carried out directly by local authorities from their social care budgets
- £2.7 billion of user contributions to local authority-arranged care, from those who fall above the lower limit of the means test but below the upper limit – i.e. those who, in England, have assets (excluding their home and pension) between £14,250 and £23,250.
- £2.6 billion local authorities receive from their local NHS Trusts for care which forms part of the social care package, but has to be carried out by medical staff who are not social care workers, such as nurses. Local authorities are not under statutory duty to provide and commission those services, as that is the role of the NHS Trusts. Where those services are required as part of social care, it is the NHS Trust which covers the cost, not the local authority.
- £0.3 billion in other income

On top of the £20.4 billion accounted for above, around £10.9 billion is spent by self-funders – individuals who fall above the upper limit of the means test by having assets (excluding their home and pension) in excess of £23,250.

Finally, £3.2 billion is spent by the voluntary sector, bringing the total figure to £34.5 billion.

25. p8, <https://www.ageuk.org.uk/globalassets/age-scotland/documents/ia---factsheets/care/care-5-care-home-guide-funding.pdf>

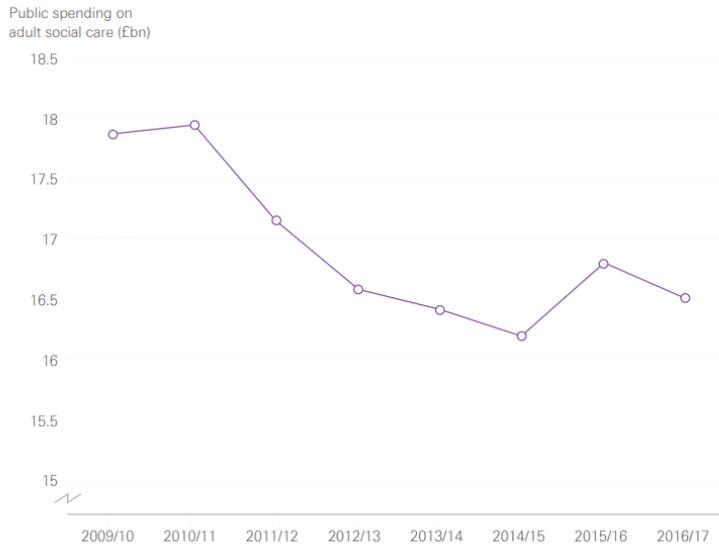
26. <https://careinfoscotland.scot/topics/care-homes/paying-care-home-fees/capital-limits/>

27. <https://gweddill.gov.wales/topics/health/social-care/care/?lang=en>

28. NAO, Adult social care at a glance, July 2018, p10, <https://www.nao.org.uk/wp-content/uploads/2018/07/Adult-social-care-at-a-glance.pdf>

Public spending on adult social care in England, 2009/10 to 2016/17

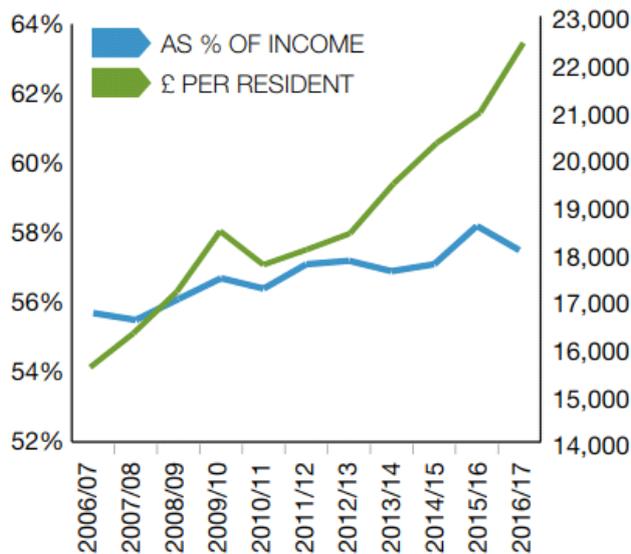
Figure 2: Public spending on adult social care in England, 2009/10 to 2016/17 (2017/18 prices)



Public spending on adult social care (£bn). Source: NHS Digital personal social services expenditure and unit costs; DCLG local authority revenue expenditure and financing.

Despite low inflation, costs have gone up substantially as a result of changes to regulation and expected care standards and as a consequence of wage regulation. Increases in the minimum wage have had a serious effect in a system heavily dependent on unskilled labour.²⁹

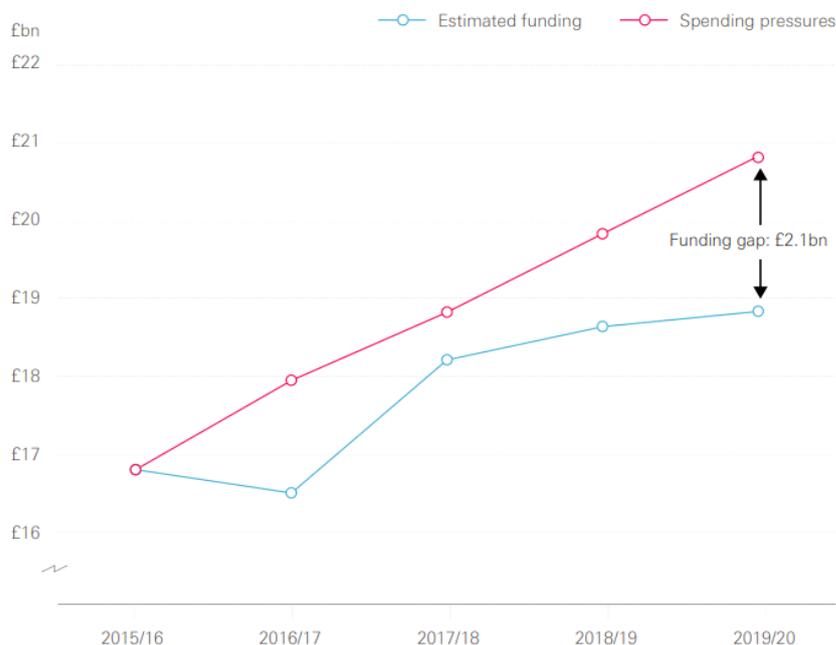
Staff costs



Source: Knight Frank Research

29. Vadean, F and Allan, S, 'The effects of minimum wage policy on the long-term care sector', July 2017, Personal Social Services Research Unit, <https://www.pssru.ac.uk/pub/5335.pdf>

Social care funding gap, 2016/16 – 2019/20



Gap between estimated public spending on adult social care and funding pressures (2017/18 prices). Source: Health Foundation analysis based on multiple sources

The size of the care market

As of 2017, 410,000 residents live in 11,300 care homes operated by 5,500 providers.³⁰ 95% of beds are provided by the independent sector – commercial for-profit (83%) and charity-run (13%).³¹ The final 4% are operated by local government or the NHS.³² There are regional differences: in England 3.2% of the homes are in the public sector, in Northern Ireland it is almost 10%, in Wales 13.5% and in Scotland 15.3%.

Overall, the Care Quality Commission (CQC), in its report *The State of Adult Social Care Services 2014-17*, estimates that in the community, personal care is provided for more than 500,000, most of it offered to people in their own homes by domiciliary care services as well as in other care settings such as extra care, housing, Shared Lives schemes, and other supported living services.³³ There are around 8,500 separate providers for domiciliary care services.³⁴ It also estimates that adult social care accounts for around £20 billion in the economy. It employs 1.4 million people, representing 5.3% of the total workforce in England.³⁵

The Structure of the Social Care Market

Over half of those in this overwhelmingly private-sector market have their care paid for to some degree by the public sector. The trend for councils to exploit their bulk purchasing power to drive prices below the cost of the provision of providing the care has been a longstanding feature of the market in social care but it has become more pressing over the last seven years as employment and other costs have risen. In consequence,

32. Ibid
 30. <https://www.gov.uk/government/publications/care-homes-market-study-summary-of-final-report/care-homes-market-study-summary-of-final-report>
 31. Ibid
 33. Ibid
 34. https://www.cqc.org.uk/sites/default/files/20170703_ASC_end_of_programme_FINAL2.pdf pp. 5
 35. Ibid

self-funders subsidise the rest and the sector increasingly directs new investment towards self-funders and away from council-purchased care. This has been reflected in the chosen location of new care homes in places where there will be a higher proportion of self-funders.³⁶ Capital spending on homes principally used by councils has generally been limited to the amount necessary to comply with minimum care standards.

Between 2010 and 2014 the amount spent per week on a residential and nursing home place paid for by local authorities in England fell from £673 to £611. According to the CQC's *The State of Health Care and Adult Social Care in England 2015-16*, care homes where more than half their turnover was financed by councils reported that compared to other providers, their fee income per bed was 10%, and profits per bed 28%,³⁷ lower. The CQC suggested that the adult social care sector was approaching a tipping point resulting from financial constraints resulting in unmet need, care homes withdrawing from providing places for local councils and in some instances handing back home-care contracts to them. Data from the Association of Directors of Social Services (ADASS) given to the CQC suggests that 32 local authorities had residential or nursing contracts given back to them in the six months to May 2016.³⁸ In rough terms, in England the difference between what councils are paying and what they should be paying to meet a reasonable estimate of the actual cost of providing the care, is around £1.3 billion.

Falling profits

Against this background of concern the CMA undertook a financial analysis to assess the social care sector in the short, medium and longer terms. Using data from audited financial statements held at Companies House from 4,232 care companies, they found that between 2010 and 2015 average annual revenues were £10.4 billion. This represents just less than three quarters of the total £15.9 billion market. The CMA constructed a separate data set of financial information from the twenty-six largest providers between 2015 and 2016: they operated 2,115 care homes and their annual revenue was £4.3 billion, representing a third of the market by revenue.³⁹

Between 2010 and 2015 profits in the sector provided a consistently positive operating margin. The CMA conclusion is that operating margins are broadly stable and have held up quite well and overall the sector has been able to cover higher costs with higher fees. But they have also found that in terms of economic profits that take account of the cost of capital and investment the sector is close to just breaking even, and given rising staff costs and uncertainty surrounding future fee income, financial performance in the sector will decline. That raises questions about its long-term viability.

This graph shows how profits in the care home sector are falling. The measure is EBITDARM.

36. Page 14 <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf>

39. https://assets.publishing.service.gov.uk/media/59b2bb0ae5274a5cfcda2d18/financial-analysis_working_paper.pdf pg8

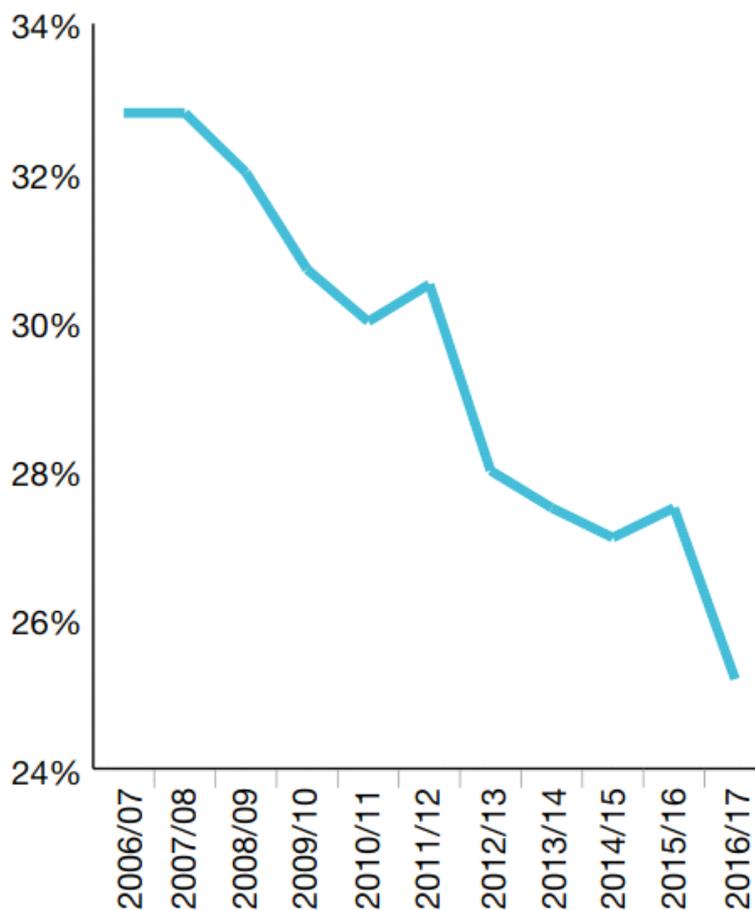
37. https://www.cqc.org.uk/sites/default/files/20170703_ASC_end_of_programme_FINAL2.pdf pp. 5

38. https://www.cqc.org.uk/sites/default/files/20161019_stateofcare1516_web.pdf pg46

EBITDARM

Earnings before Interest, Tax, Amortisation, Rent and Management

This is a particular measure of profitability which allows for direct like-for-like comparison between individual care homes, before costs of rent and management charges are accounted for.



Source: Knight Frank Research

The CMA’s assessment is that the average fees paid by local authorities are below the full costs of looking after the people whom they place into care homes. Its financial analysis, which is the most comprehensive examining the sector, suggests that overall the sector is just able to cover its operating and capital costs thanks to self-funders. But this is not the case for care homes mainly providing care financed by local authorities, many of which the CMA considers are not in a sustainable position. The fees paid by the public sector are on average as much as 10% below the total cost.⁴⁰ While they can cover day-to-day operating costs they are not able to finance additional investment.

These homes may be able to stay in operation in the short run, but they will not be able to modernise their facilities to meet rising expectations and future inspection standards, let alone acquire the new technology that could vastly improve productivity and quality of care. The CMA estimates that these homes will have to close eventually or move out of the council-

40. <https://www.gov.uk/government/publications/care-homes-market-study-summary-of-final-report/care-homes-market-study-summary-of-final-report>

funded segment of the market. As a House of Commons Library Briefing Paper has noted in May 2019, the CMA's judgement was prescient.⁴¹ This is illustrated by the Big Four care home providers, that provide 14% of all beds are currently up for sale. Three of these four providers have been available for sale for around a year, while one of them has gone into administration. This demonstrates the fragility of the social care market.

Since the current fees paid by the public sector are insufficient to maintain the present funding model of care and around a quarter of care homes have more than 75% of their residents funded by the state, this vital segment of the market is likely to fail, or cease offering homes to local authorities for bulk purchase.

It was 1988 when Sir Roy Griffiths presented his second report. Thirty years on, we remain faced with a rickety structure, an ageing demographic, an unfair pricing system, rising costs and low investment: the system is creaking.

41. Tim Jarrett, Social Care: Forthcoming Green Paper (England) 13 May 2019, HOC Library Briefing, <https://researchbriefings.parliament.uk/Research-Briefing/Summary/CBP-8002#fullreport>

2. What are the problems?

An issue that affects young and old alike

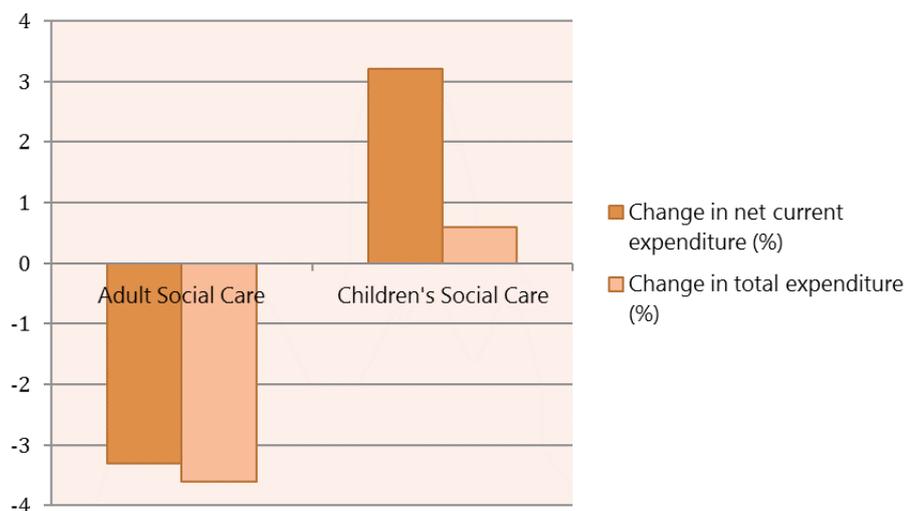
Social care is often considered in the wider public debate as involving only the very elderly. Yet many families will have the experience of a person under the age of 65 needing care of a protracted and expensive nature as the result of chronic conditions like rheumatoid arthritis, muscular dystrophy or serious mental health problems, or the early onset of dementia or Parkinson's disease. Indeed, there were over 1.8 million new requests to local councils for adult social care in 2015/16, of which just over a quarter were from adults aged 18 to 64.⁴² The resulting costs and the virtual wiping out of savings can have a devastating impact on a surviving spouse, who may go on to live in straitened circumstances for many years. Families where a parent has a debilitating stroke at an early age in their thirties or forties run the risk of having their savings almost wiped out. This is one of the inequities that the government ought to deal with.

Intergenerational unfairness and our relative parsimony towards the old

It is striking that since 2010 almost all public services have seen discretionary reductions in public expenditure, including spending on adult social care. Yet spending on children's services has risen, which illustrates not just the lack of relative priority given to social care within overall health and social care spending but arguably to provision for older people within public expenditure as a whole.

42. <http://www.content.digital.nhs.uk/catalogue/PUB21934/comm-care-stat-act-eng-2015-16-rep.pdf> pp. 5

Change in net current and total service expenditure, 2010-11 to 2016-17



All local authorities in England. Sources: National Audit Office, Financial Sustainability of Local Authorities

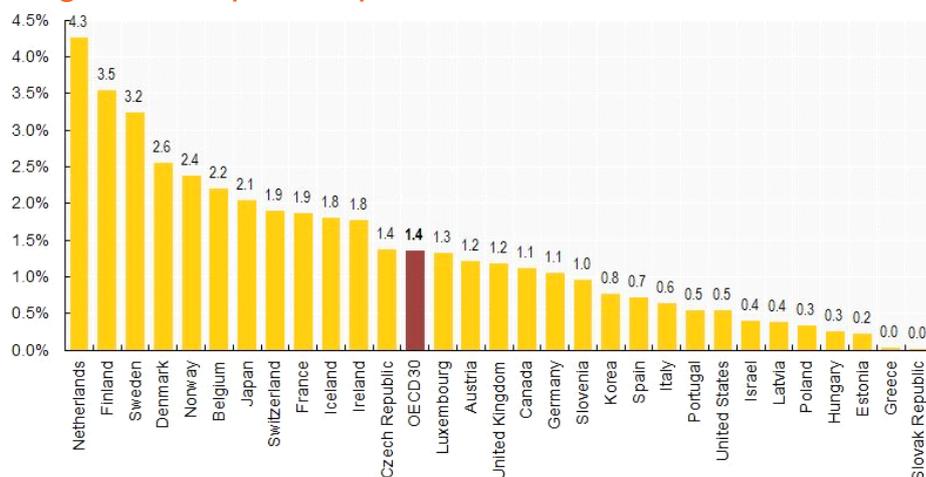
The care deficiencies are particularly glaring, especially for those whose discharge from hospital is delayed because appropriate care plans cannot be put in place, either through a lack of care available from family and friends or from the local social services department. OECD figures for spending on day-to-day activities such as washing, cooking, dressing and cleaning that are regarded as being long-term care show that internationally demand for care is rising but there is considerable disparity of provision between countries, with the UK coming off badly. UK spending on long-term care was 1.2% of GDP in 2013-14 (the nearest year available with comparable data) – noticeably below the OECD average.

Most countries tend to provide more coverage of health than social care, yet as the King's Fund has noted in its paper *The Social Care and Health Systems of Nine Countries*, the gap between the two is generally less stark than in England.⁴³

43. King's Fund, *The Social Care and Health Systems of Nine Countries*, (2014) pp. 11

We neglect the old

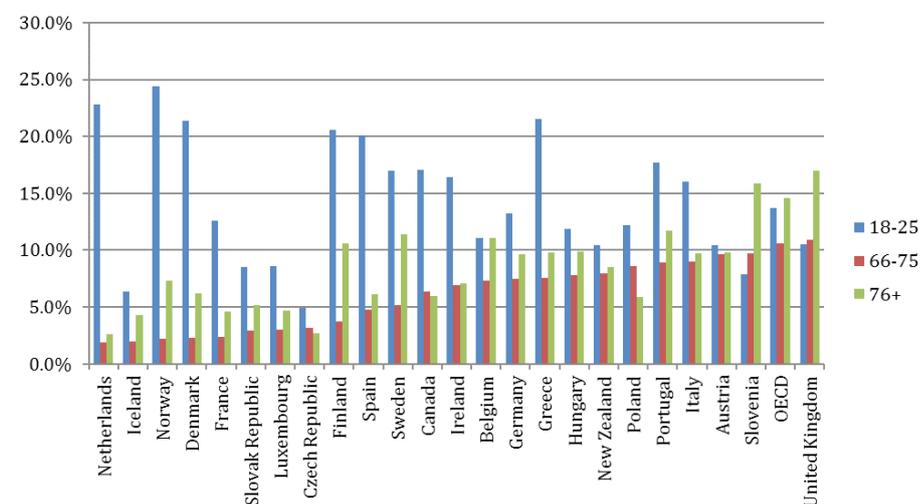
Long-term care public expenditure



Health and social care components, as share of GDP, 2014 (or nearest year)

Not only are we mean with health and social care, which matter disproportionately to the old, but because of an historically low basic state pension, they are markedly poorer than their counterparts in other advanced economies when it comes to what the OECD calls relative income poverty.

Relative income poverty



Percentage of persons living with less than 50% of median equivalised disposable income, by age group in 2014 (or nearest year)⁴⁴

In many respects, the kinds of help that the public sector might be expected to provide to householders at the end of their lives are relatively underdeveloped financially in the UK compared to other advanced economies.

There are many ways in which elderly people are treated with a lack of

44. <http://www.oecd.org/unitedkingdom/PAG2017-GBR.pdf>

generosity, including:

- health spending has tended to focus on acute rather than chronic conditions and social care
- the basic state pension is remarkably ungenerous
- low incentives to save for private pensions

The present provision for most pensioners comprises the basic state pension that provides a basic level of retirement income, and the state second pension, which is related to earnings. Since April 2016, this has been replaced by a single-tier pension for newly retired pensioners. The state pension age is set to rise from 65 to 66 for both men and women in 2020.

After a brief period in the 1970s, when it was indexed to whichever was the higher of either earnings or prices, the basic state pension's value in relation to average earnings was squeezed from 1981 until 2010. The present uprating regime (the so-called 'Triple Lock'), introduced in 2010, which indexes the pension by inflation, earnings or 2.5%, whichever is higher, represents a very modest improvement.

Those in the UK with few additional resources for financing their retirements other than the state pension are exposed to poverty in old age. The OECD points out that these income disparities will rise as the generation in their late fifties and early sixties approach retirement. Poverty rates among people aged over 75 are 18.5% compared to 11% in the whole population.

Once the UK's private pensions are added to the state pension, the average income in retirement for UK pensioners rises to just over 60% of former career earnings, just below the OECD average.⁴⁵ However, according to the Melbourne Mercer Global Pension Index 2017, which calculates overall pension provision, the UK system provides lower and less sustainable pension provisions than Norway, Finland, Sweden, Singapore, Switzerland, New Zealand, Chile, Canada, Ireland, Denmark, Netherlands and Australia.⁴⁶

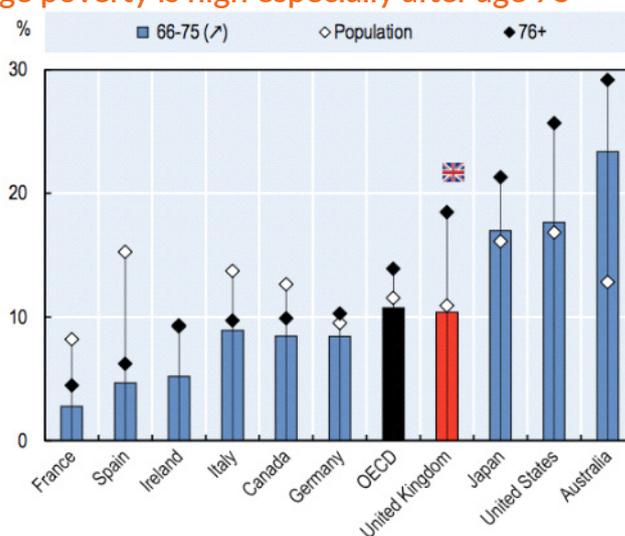
In the UK, full-career average earners can expect 29% of their average earnings on retirement. By contrast, the OECD average is 63%. Only Mexico and Poland have lower rates for low earners.⁴⁷

45. Ibid

46. https://australiancentre.com.au/wp-content/uploads/2017/10/2017_MMGP_Report.pdf

47. <http://www.oecd.org/unitedkingdom/PAG2017-GBR.pdf>

Old-age poverty is high especially after age 75



Relative poverty rates by age group, 2014 or latest year available. Percentage of persons living with less than 50% of median equivalised disposable income.

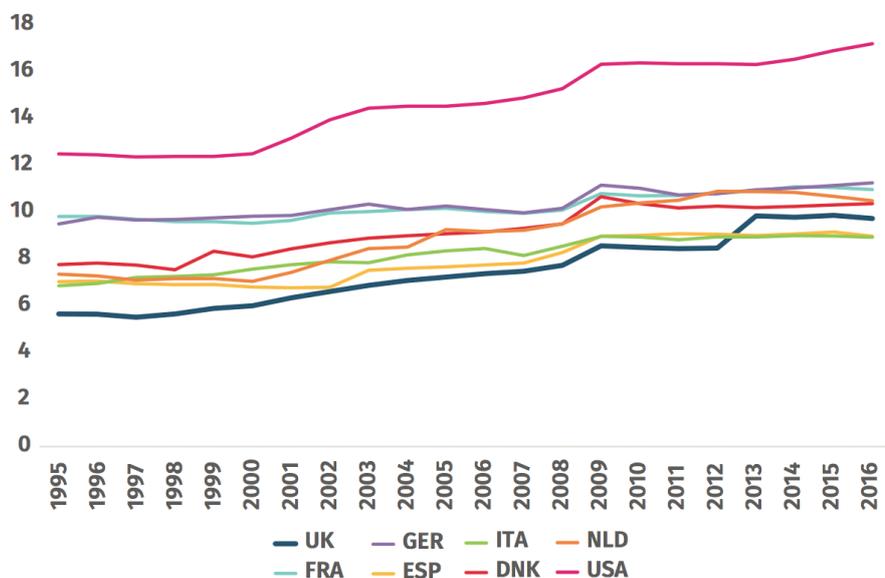
In contrast to spending on pensions for older people, spending on transfer payments for households of working age has increased significantly in the last 20 years. Over the last 40 years, support for families with children has increased hugely, even though since 2010 these transfer payments have been constrained by the measures taken to eliminate the UK structural budget deficit. The creation of child benefit out of the old income tax allowance, the introduction of Family Income Supplement, Family Credit, and the tax credit system created after 1998 have largely fulfilled the agenda of Sir Morris Finer’s 1974 report on lone parent families. The striking feature of the evolution of transfer payments over the last 30 years is not so much the growth in spending on pensioner households, which accounts for about 4.7% of GDP,⁴⁸ but the growth in spending on tax credits to households of working age. These now account for around 13% of welfare spending and have risen sharply in cash terms from £1bn in 1985-6 to £30bn in 2015-16.⁴⁹

The UK’s parsimonious approach to the provision of health, social care and basic pension benefits to older people partly explains why it has fewer unfunded long-term intergenerational liabilities than other advanced economies. In international forums, such as the EU commission and the OECD, officials from other countries are initially impressed by this but when they ask for guidance on how it has been achieved, they also express scepticism about whether the UK will be able to continue to constrain these elements of spending in as stringent a manner.

48. <http://obr.uk/forecasts-in-depth/brief-guides-and-explainers/an-obr-guide-to-welfare-spending/>

49. <http://obr.uk/forecasts-in-depth/brief-guides-and-explainers/an-obr-guide-to-welfare-spending/>

The UK spends less than comparable developed countries on healthcare



Healthcare spend as a percentage of GDP, 1995-2016. Source: OECD, Carnall Farrar Analysis

	Care Costs	Accommodation Costs	Ancillary Costs	Operator's Profit	Total Costs and Profit
Residential care frail elderly	£197	£151	£205	£44	£596
Nursing care frail elderly	£347	£153	£205	£59	£764
Residential care dementia	£221	£151	£205	£47	£623
Nursing care dementia	£356	£153	£205	£60	£774

A more general point is worth noting. Social security spending and transfer payments, as well as benefits-in-kind such as education and health care, tend to be concentrated on young people in the early stages of life and on older people after retirement age. This reflects earnings over the life cycle, where young people have little in the way of income. Incomes rise in middle age and peak during 40s, and then begin to tail off.⁵⁰ Inevitably, in a market economy with a wide dispersion of income, welfare spending is concentrated on older people and very young people, and is financed by people in middle age.

The Demographic Pressures of An Ageing Society

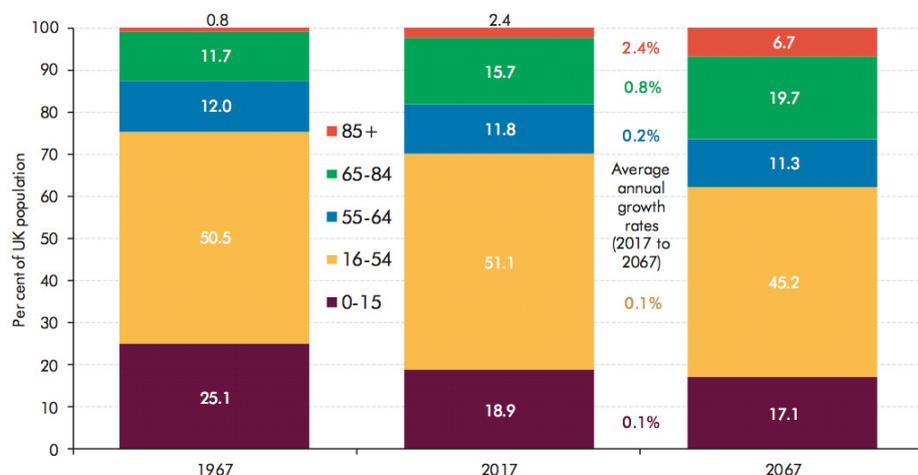
The context is that the UK, in common with other advanced societies, faces a serious demographic challenge. This arises from an ageing population, where health, other services and incomes in retirement, are significantly, if not principally, provided by the state. This is not a cause for lamentation: people live longer and more healthily because of advances in medical care.

However, the size and age structure of the population has significant indications for both the economy and for public finances. The Office for Budget Responsibility (OBR) uses Office of National Statistics (ONS) projections of how the population structure will evolve as its basis for

50. In 2018, Full-time gross weekly earnings peaked at ages 40 to 49 years for men (£708) and ages 30 to 39 years for women (£575), ONS, Annual Survey of Hours and Earnings (ASHE) April 2018, Figure 10,

forecasting the economy and public finances.

Population structure in 1967, 2017 and 2067



Source: OBR FSR July 2018, pp. 50

In 1991, 15.8% of the UK population was over 65: by 2016 this had risen to 18%. Part of the increase has been driven by declines in mortality rates. For example, male and female children born in the UK today can expect to live respectively to 79.2 and 82.9 years.⁵¹

Projections of future demography turn on assumptions about patterns of future mortality, fertility, immigration and life-expectancy. All are based on complex forecasts and assumptions, and are vulnerable to changing circumstances. The OBR, for example, have noted in their *Fiscal Sustainability Report* (July 2018) that mortality rates have started to rise with reducing longevity.⁵² This is the first time that life expectancy has actually fallen in the UK but it reflects a clear trend that has been taking place since 2010 where the rate of growth in life expectancy has plainly been slowing. Data from the Institute of Actuaries suggests that the trend may even have been earlier and started around 2005.⁵³ A similar pattern of slowing rates of growth in life expectancy has been observed in other advanced countries such as Australia, Canada and the Netherlands. This has significant implications for the long-term tractability and affordability of pensions and other support for older households both in relation to public policy and private pensions.

Nevertheless, the ONS expects the number of people aged 85 and over in England to double over the next twenty years.⁵⁴ The challenge for social-care practitioners is that more than a third of people over the age of 85 exhibit significant frailty.⁵⁵ The *English Longitudinal Study of Ageing*, for example, finds that more than a third of people over the age of 85 are carrying out five or more tasks of daily living without assistance and are therefore likely to need health or social care services.

Healthcare requirements increase with age. And healthcare costs increase steeply from around 65.

51. Ibid; pp. 11

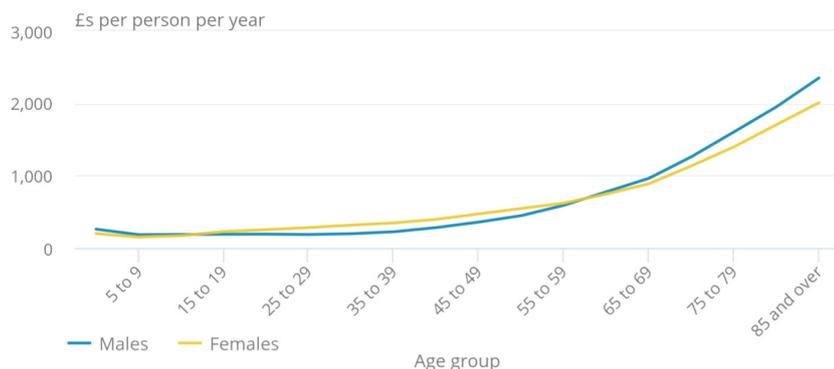
52. pp. 51; "Life expectancy has been revised down significantly, reflecting higher-than-expected death rates. For example, the period measure of life expectancy in 2041 has been revised down by one year (for both men and women) while the cohort measure, which factors in projected future changes in age-specific mortality rates, has been revised down by 1.5 years for men and 1.7 years for women. Between the 1975 and 2008 population projections, deaths were systematically overestimated as the continued rise in longevity was underestimated. But since then, the ONS has revised deaths up a little in the nearer term, while leaving its long-run assumptions broadly unchanged."

53. Chris Seekings, 'Falling life expectancy to slash pension scheme liabilities', *The Actuary*, 11 March 2019, <https://www.theactuary.com/news/2019/03/falling-life-expectancy-to-slash-pension-scheme-liabilities/>

54. ONS 2015, 2014-based National Population Projections

55. Marmot M and others, *English Longitudinal Study of Ageing, Waves 0-7, 1998-2015*, 25th Edition, UK data services SN: 5050

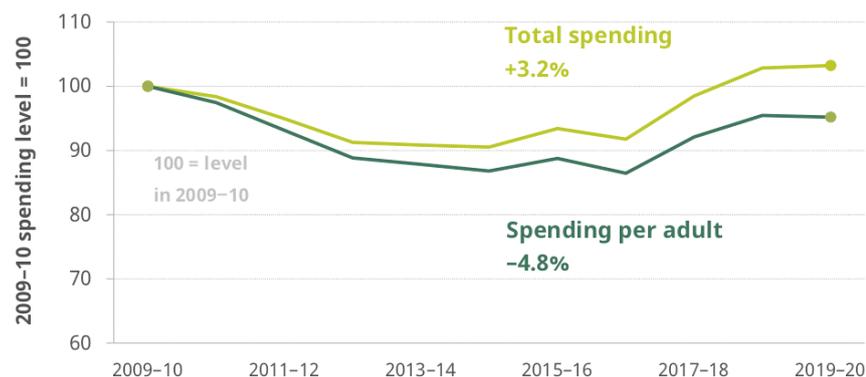
NHS general and acute care age-cost curve, 2013 to 2014, England



Source: *Technical Guide to Allocation Formulae and Pace of Change, 2016 to 2017, NHS England*

As the numbers of old people grow, and funding decreases, resources have to be spread more thinly.⁵⁶

Spending on local-authority-organised adult social care, 2009-10 to 2016-17



With these demographic challenges in mind, the main problems afflicting the care sector are:

- Its unworkable structure
- Its economic unsustainability
- Its unfairness

1. The Unworkable Structure

The exclusion of social care from the health service financed by the state has led to a series of perverse consequences for individuals and for the NHS. The separate charging regimes make it difficult to co-ordinate the different aspects of medical and social care within the health system. The fact that social care remains the responsibility of local authorities means

56. Public spending on adult social care in England: <https://www.ifs.org.uk/uploads/publications/wps/WP201815.pdf>

that ensuring consistent working between hospitals, GPs and social service teams presents a challenge that is aggravated by the differences in funding and charging and is at the centre of the difficulty in getting effective co-ordination between them.

Yet for the chronic conditions requiring social care the UK has traditionally required heavy co-payments if not the full recovery of cost. So, in the one part of the continuum of health and social care where private insurance is unprocurable, households are subject to a rigorous means test that results in a substantial number being left with ruinous costs. This is in many respects a perverse public policy outcome although it reflects a wider set of distorted priorities that have been exhibited in the NHS since its foundation.

Over the last seventy years, this separation of health and social care has become more perverse as the community has aged and more people have developed serious chronic social-care needs. These conditions involve recurrent and often increasingly expensive forms of care that over several years will exhaust the principal assets of most households.

The difficulties of establishing a coherent relationship between local authority social services departments and the NHS

Policy makers and practitioners have long aspired to co-ordinate health and social care by having more joined up and collaborative working between local council social service departments and NHS providers. *Integrated care: organisations, partnerships and systems*, a 2018 Health and Social Care Select Committee report, effectively made the same arguments as a *National Health Service Reorganisation White Paper* published back in 1972. Both recognised the need for far more “services that support people outside hospital. Often what is here could achieve more if it were better co-ordinated with other services in and out of hospital”, as the 1972 report put it.

For over thirty years there has been a succession of initiatives to promote joint working between the NHS and local authority social services departments. In June 2013, the government announced the creation of the Better Care Fund, with a single pooled budget, designed to give an incentive to work together more closely to improve or maintain people’s wellbeing. In 2015-16, its £3.8 billion included £300 million for general reablement funding in, for example, intermediate care. NICE reported that reablement services have helped more people to live at home after transfer from hospital.⁵⁷

In the 2015 Spending Review, with the objective of achieving improved outcomes, a better patient experience and financial savings, a target was set for integrated health and social care across England by 2020, with local authorities required to develop plans to achieve this objective by April 2017. The NHS in 2015-16 was instructed to set a target for 20% of England to be covered by new care models by the end of the financial year 2017-18 and 50% by 2020.⁵⁸

But the NAO in evidence to the Health and Social Care Select Committee expressed the view that there was insufficient evidence to demonstrate that integrated care leads to better outcomes, financial savings or reduced

57. https://www.nice.org.uk/guidance/ng27/resources/costing-statement-2187244909_pg7; Measures from the Adult Social Care Outcomes Framework, England, 2013-14 Health and Social Care Information Centre

58. https://www.england.nhs.uk/wp-content/uploads/2015/12/05.PB_17.12.15-Annex-A-Mandate-to-NHS-England.pdf pg17

hospital activity. “Integrating the health and social care sectors is a significant challenge in normal times,” said Amyas Morse, head of the National Audit Office in 2017, “let alone times when both sectors are under such severe pressure. So far, benefits have fallen far short of plans, despite much effort. It will be important to learn from the over-optimism of such plans when implementing the much larger NHS sustainability and transformation plans. The Departments do not yet have the evidence to show that they can deliver their commitment to integrated services by 2020, at the same time as meeting existing pressures on the health and social care systems.”

NICE set out potential savings for healthcare commissioners, clinical commissioning groups and NHS England if better integration between community and hospital multidisciplinary teams, as well as improved coordination of a person’s discharge from hospital, avoided or shortened stays. But it too was cautious about the capacity to estimate these savings at a local and national level.

The Health and Social Care Select Committee’s report *Integrated care: organisations, partnerships and systems*, hints obliquely at why the latest attempt at joint working has been no more successful than its predecessors. The report quotes evidence from Sir Simon Stevens, the Chief Executive of NHS England, to the effect that **“structural divides imposed when the NHS was originally founded no longer make sense today: for example, the distinction between an NHS that is free at point of use and a means tested social care system, or the contractual separation of general practice from other NHS services”**.

So while in principle the National Audit Office (NAO) and National Institute for Health and Care Excellence (NICE) analyses show that a better alignment of social and health care provision could improve the quality of care for the individuals involved and save money, there is no clear evidence that the Better Care Fund and the ambitious agenda of care plans for England have been any more effective in integrating care and achieving results than all the other joint initiatives. On the ground, the results are disappointing.

In his evidence to joint House of Commons Health and Social Care and Housing, Communities and Local Government Committees, Sir Simon developed this theme further: “so we have very significant funding streams, each with different, arguably cross-cutting or contradictory eligibility criteria. Without in any way understanding the complexity of a form of coherence or streamlining, that would appear to be important in any durable medium-term answer.”⁵⁹

The Joint Select Committee used continuing healthcare funding - where the NHS provides a modicum of social care funding for people who have needs arising directly out of medical care - as an illustration of the practical difficulty of a hard boundary between health and social care.⁶⁰ The patient and those responsible for organising the care have to navigate long waits to get decisions, and long waits for the outcomes of appeals and a gulf between what has been described as the “untold riches of health care funding” compared to the means-tested social care.⁶¹

59. Long-term Funding of Adult Social Care, pp. 31

60. Ibid

61. Ibid

Northern Ireland: An integrated structure doesn't automatically solve the problem

In Great Britain – England and the devolved territories of Wales and Scotland – social care has been the responsibility of local authority social services departments while health is the responsibility of the NHS. Northern Ireland, though, has had integrated structures for health and social care since 1973, yet it has been slow to exploit its potential benefits. The 2013 King's Fund report *Four UK Health Systems: Learning from Each Other*, noted that “Northern Ireland represents a missed opportunity to demonstrate on a system-wide basis what can be achieved when the organisational barriers to the integration of health and social care are removed”.ⁱ

The OECD's *Reviews of Health Care Quality: United Kingdom 2016* found when looking at health and social care providers, that “with funding and service arrangements still in silos and a lack of incentives to encourage change,” Northern Ireland was “lagging behind”. It raised concerns that the governance structures might be “over engineered and burdensome” and made recommendations for further integration of general practice as “a principal agent for co-ordinating community responses to health and wellbeing needs”. Among what the OECD suggested were better comparisons and benchmarking between trusts, a core set of quality clinical and social care standards and better public reporting of the quality of service provision to improve transparency.ⁱⁱ

A *General Report on the Health and Social Care Sector 2012 to 2013 and 2013 to 2014* by the Public Accounts Committee (PAC) published in January 2016, confirmed that the pace of change in Northern Ireland was too slow. It recommended a more flexible system, like that which exists in Scotland, which “would involve a move from annual to medium-term financial planning to avoid the annual budgetary constraints and monitoring round bail-out arrangements which currently afflict trusts”.ⁱⁱⁱ

The aim of the Government's consultation, *Health and Social Care Reform and Transformation – Getting the Structures Right*, was to test opinion on whether more structural reform was needed; its response in March 2016 confirmed it would be moving ahead with its agenda. Despite historical advantages, Northern Ireland now seems to be falling behind on the sort of service reform that has been carried out in other UK countries. Its experience illustrates the “Shared Commitment” statement made in 2013 by England's National Collaboration on Integrated Care and Support, which says: “Integrated care is not about structures, organisations or pathways, nor about the way services are commissioned or funded. It is about individuals and communities having a better experience of care and support, experiencing less inequality and achieving better outcomes.”^{iv}

The experience of Northern Ireland illustrates that institutional propinquity alone will not overcome the entrenched influence of the medical lobbies that give priority to acute medicine over chronic health care and social care nor the difficulty of co-ordinating a free and a charging system.

Preventative care

In the the overall balance between health and social care spending in the years ahead, greater emphasis could be given to social care provision and the preventative and ‘reablement’ work – helping restore independence after an illness - that social services and the third sector can contribute in the community. Much of this preventative work such as visits by occupational therapists and home care services prevents people from needing much more expensive provision. As a Government Office for Science report commented in 2015:

i. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_summary/four-uk-health-systems-jun13.pdf

ii. https://read.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-health-care-quality-united-kingdom-2016_9789264239487-en

iii. <http://www.niassembly.gov.uk/globalassets/documents/reports/public-accounts/report-general-health-report.pdf> pp. 8

iv. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf

‘If appropriate management of future pressures on the health and social care environment is to be delivered, the system needs to be rebalanced toward well-being interventions, and primary, secondary and tertiary prevention. However, the budget for such care is continually under threat.’⁶²

Keeping people out of hospital and from needing complex social care either at home or in a residential care setting is good for them and helps to lower costs. In the future, social care not only needs to be better funded with greater coherence between health and social care assessments and user charges more closely aligned but greater priority should be given to preventative work in the community.

2. The Economic Unsustainability

The underfunding of care, the uncertainty about future funding, and the fact that much of the present system is possible only through the differential pricing regime that penalises self-funders, means that care providers are reluctant to engage in new investment for places that will be bought by local authorities.

If high-quality, personalised care and support is to be available, there has to be a reliable market of quality service providers. The role of local authorities in spreading best practices is vital to achieving this: under the Care Act 2014, they are required to research and publish market-shaping reports.⁶³ The CMA has looked at a sample of twenty councils and has seen different approaches ranging from rudimentary to detailed and innovative. Further, none of them offered estimates of the additional capacity that is likely to be needed. The CMA recognises, however, that in practice local authorities have few tools or policy levers to develop a market in social care.⁶⁴

An analysis of the revenue streams shows that local authorities account for roughly half the revenue received by providers of care. Revenue from self-funding residents accounts for slightly more than a third of the income of care homes.

Crucially, local authorities cannot offer effective incentives to encourage care companies to invest in providing the service in their communities. Financial pressures mean decisions about long-term investment in capacity are being deferred until there is confidence about a reasonable and reliable rate of return. As the CMA put it in evidence to the Joint Select Committee on the Long-term Funding of Adult Social Care, “local authorities’ market shaping plans did not give providers the information they needed to plan ahead and make investments.”⁶⁵ The Select Committee reported that funding pressures on care homes had been increased by local authorities taking a short-term approach to market shaping and engaging in commissioning practices such as reverse auctions to deliberately drive down the price of care.⁶⁶

The care sector is highly fragmented: 80% of care home providers operate a single home and account for 29% of beds, while the 30 largest care home providers supply 30% of the total. The average care home has 40 beds, but as the industry now considers the optimum size of a care home to be around 60 to 70, the size of homes has been increasing in recent years.⁶⁷

62. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/460109/gs-15-24-future-ageing-supportive-services-role-er14.pdf

63. <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>

64. <https://www.gov.uk/government/publications/care-homes-market-study-summary-of-final-report/care-homes-market-study-summary-of-final-report>

65. Long-term funding of adult social care, <https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/768/768.pdf> pp. 13

66. Ibid

67. CMA

Economies of scale in the sector are, however, perceived to be limited. Although the CMA considers larger homes more economically viable in the long-term, the CQC reports from inspection data, the judgements of professionals and the experience of residents’ families, that homes with more than 70 beds are perceived as impersonal and smaller homes are more highly rated.⁶⁸



Source: CQC ratings data, 5 May 2017. Figures in brackets are numbers of locations rated. Small = 1-10 beds, Medium = 11-49, Large = 50+

When the Commission turned their attention to domiciliary care services, their data suggested a similar story. The CQC ratings data show that 85% of small services (for 1-50 people) and only 73% of larger services (for 101 to 250) were rated as good or outstanding.⁶⁹

68. CQC The State of Adult Social Care Services, pp. 19

69. https://www.cqc.org.uk/sites/default/files/20170703_ASC_end_of_programme_FINAL2.pdf pp. 21

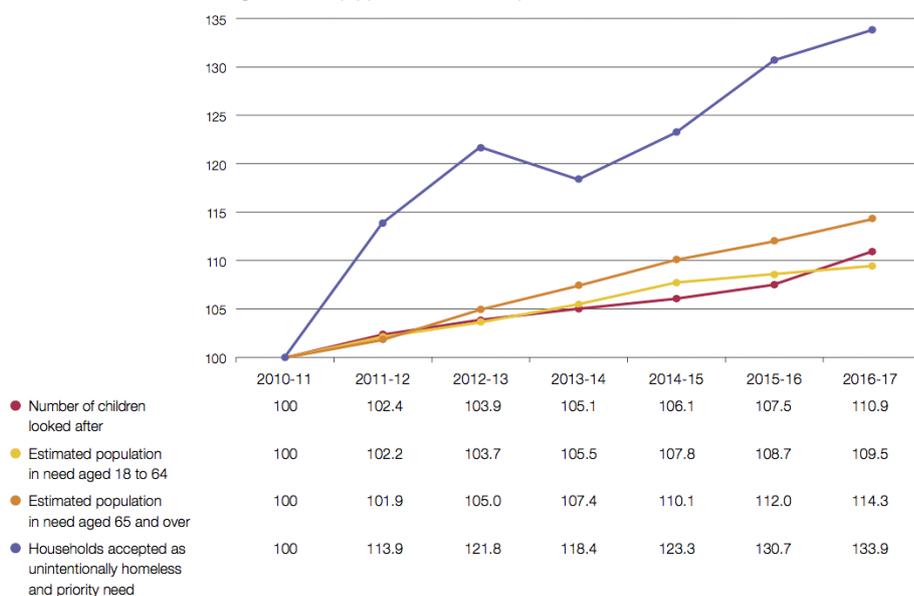


Source: CQC ratings data, 5 May 2017. Figures in brackets are numbers of locations rated

Source: CQC ratings data, 5 May 2017. Figures in brackets are numbers of locations rated.

During the years of squeezed spending and increasing costs, as local councils used their power to shunt the financial burden on to the self-funders, the public sector failed even to invest the resources needed to fund the part of the care system that it directly commissions itself. Yet there is no avoiding the uncomfortable fact that demand for social care continued to rise even as spending fell in an environment of constrained budgets. These costs, not least the introduction of the living wage, will result in costs continuing to rise.

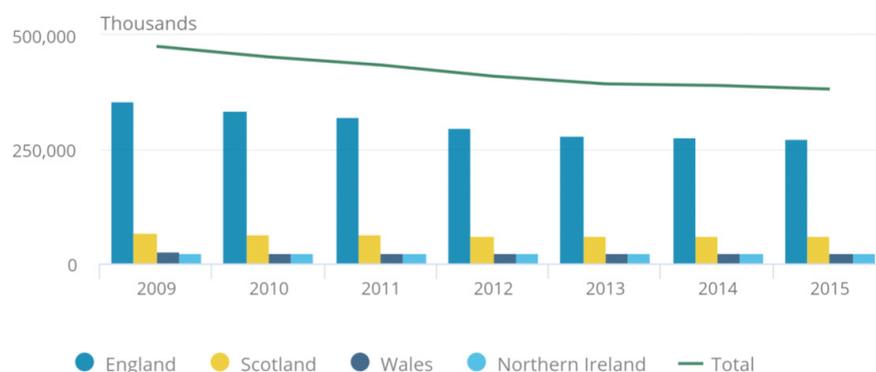
Increase in demand, 2010-17



Source: National Audit Office analysis of departmental data. See standalone methodology

Change in demand in key local authority service areas in England. Source: National Audit Office, Financial Sustainability of Local Authorities 2018, pp.20

Reduction in spending, 2009-15

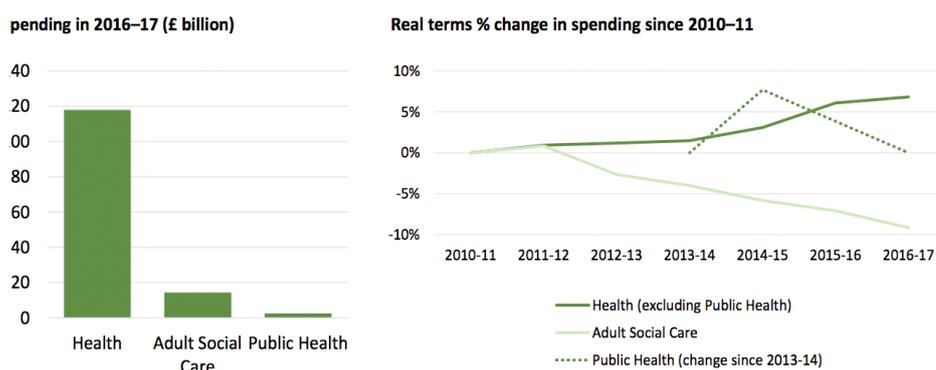


Total people receiving domiciliary care funded by a local authority or Health and Social Care Trust (HSCT) across the UK in a sample week, 2009 to 2015

The Association of Directors of Adult Social Care Budget Survey 2018 shows that social care spending is the largest area of discretionary spending undertaken by local authorities, accounting for over a third of expenditure.⁷⁰ In real terms, expenditure on adult social care fell by 5.8% between 2010 and 2017 from £15.8bn to £14.9bn.⁷¹

70. <https://www.adass.org.uk/media/6434/adass-budget-survey-report-2018.pdf> pp. 12

71. House of Commons Joint Committee, pp. 9 <https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/768/768.pdf>



Source: Library briefing paper *Adult Social Care Funding (England)*, 19 April 2018; HofC Library Briefing Paper, *NHS Funding and Expenditure*, 13 April 2018; The King's Fund, *Spending on public health*, 18 May 2017.

Given the relative costs of acute hospital-based health services, this lack of effective co-ordination results in significantly higher NHS costs. The case for ending the full charging regime and the capital test that fully takes account of the main home and for spending more money on social care is powerful in terms of efficiency, equity and NHS resource management.

The Care Quality Commission's report of October 2018 stresses this point: "If services are not well planned or coordinated, people can experience delayed transfers of care (DTC) from hospital" (p27). These delays in transferring patients towards more appropriate care settings place stress on the whole healthcare system. As well as incurring the added costs of hospital treatment, they take up hospital space, preventing new patients from being admitted. The report highlights how efforts to reduce DTC have overwhelmed social care providers, further strengthening the case for improving the funding and co-ordination of social care.

Current funding levels are inadequate to meet care costs

Among charities, analysts and practitioners working the field of social care there is a concern that spending constraints mean there is significant unmet need. For example, Age UK's *Briefing: Health and Care of Older People in England 2017* estimates that an additional £4.8bn is needed to ensure that every older person who currently has one or more unmet need has the social care that they require.⁷² Clearly the level of spending will always turn on policy guidance about the thresholds for care used in care assessments.

Part of the squeeze on spending has resulted in providers of care withdrawing from the market. The CQC's registration data shows that the number of residential homes are falling and there has been a noticeable withdrawal of carers from the domiciliary care market where local authority contracts were considered to have insufficient funding for the provider to be able to respond to a person's care needs.⁷³

The data also suggests a long-term trend where the number of nursing home beds increases and the number of residential care home beds falls,

72. http://www.kica.care/wp-content/uploads/2017/02/The_Health_and_Care_of_Older_People_in_England_2016.pdf pp. 4

73. CQC, pp. 6

but the increase in nursing home beds faltered in 2015 and since then has fallen – down by 4,000 from their peak in 2015.

3. The Unfairness

The exclusion of social care from the services financed by the state has led to a series of perverse consequences for individuals and for the NHS. Individuals with different conditions resulting in similar debilitating frailty are treated in wholly different ways by the system. Medical conditions of a relatively minor character are covered freely without charge while many people who require serious social care have to pay for it. A millionaire can have free treatment for cancer or heart disease, while someone with modest assets who needs help with the effects of, for instance, Parkinson's disease, dementia or a stroke, for getting dressed or the managing of incontinence, has to pay for their care until their assets are drawn down to the means test threshold.

This is in many respects a perverse public policy outcome although it reflects a wider set of distorted priorities that have been exhibited in the NHS since its foundation in 1948. As well as charging for social care from its earliest days, non-acute clinical conditions (such as mental illness and the chronic conditions associated with old age) have been given less priority than acute medical conditions. For many years, there has been a serious imbalance in the priority given to acute medicine over the management of chronic conditions, a lack of interest in improving those associated with older age and disability, and callous neglect of palliative care and other help for the dying.

The system makes planning for the future a lottery. For example, only a fifth of people are likely to need long-term care for a protracted period, yet for those households the costs are devastating, sometimes running into hundreds of thousands of pounds.⁷⁴ And of course that includes the hidden subsidies to the homes to make up the shortfall from local authorities.

The great majority of care homes provide places for both local-authority funded and self-funded residents. Examining the finances and practices of larger care providers, the CMA judged that self-funders pay fees that are on average 41% higher than those paid by local authorities buying places in the same home.⁷⁵ This is an average differential of £236 a week or over £12,000 a year.⁷⁶ In smaller homes the differential may be lower but is still considered by the CMA to be significant.

An analysis of the revenue streams shows that local authorities account for roughly half of the revenue received by providers of care in the market. Revenue from self-funding residents accounts for slightly more than a third of the income of care homes. This illustrates the relative significance of local authority funded residential places and its impact on the overall profitability of these providers.

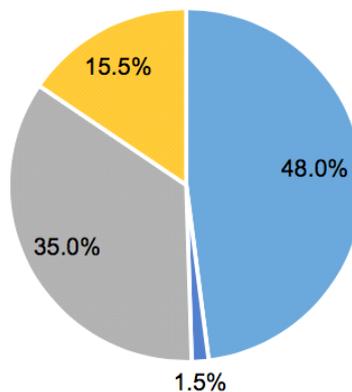
74. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/558142/comm-care-stat-act-eng-2015-16-nat-eng.xlsx

75. CMA, Care Homes Market Study Final Report (November 2017) pp. 40

76. CMA, Care Homes Market Study Final Report (November 2017) pp. 40

Total provider revenue by source of residential funding, 2015-16

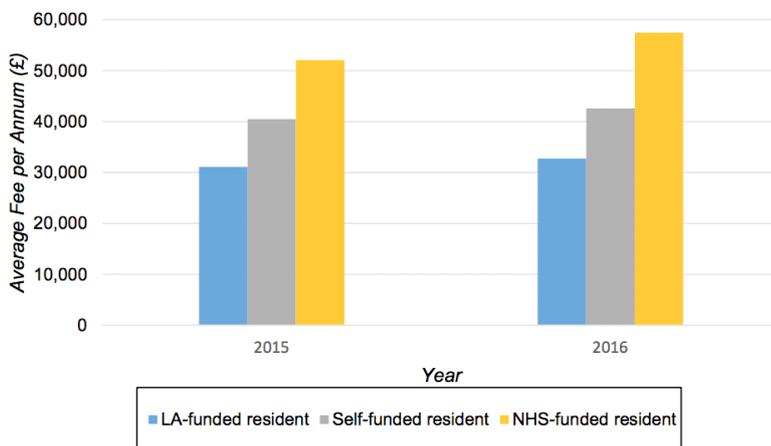
- Revenue from local authorities on behalf of local authority funded residents %
- Top-up revenue from local authority funded residents %
- Revenue generated from self-funded residents %
- Revenue generated from NHS funded residents %



Source: CMA working paper, pp.38

The average fee per resident, based on the source of funding per resident shows that, on average, less revenue is generated per local authority-funded resident than is generated by one who is self-funded.

Average annual fee per resident by source of resident funding, 2015-16



The average cost of a bed purchased by a local authority social services department is £621 a week as opposed to the £846 that is paid by the average self-funder.⁷⁷ (The average fee for residential care is £588⁷⁸ a week and £741⁷⁹ for nursing care.)

This is grossly unfair. The CMA estimate that for a self-funder the average cost of care is £44,000 a year⁸⁰ out of post-tax income. And of course that includes the hidden subsidies to the homes to make up the shortfall from local authorities.

As the CMA point out, the great majority of self-funders are not wealthy and given that the current thresholds of support from the state are so

77. <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf> pg7

78. <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf> pg143

79. <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf> pg35

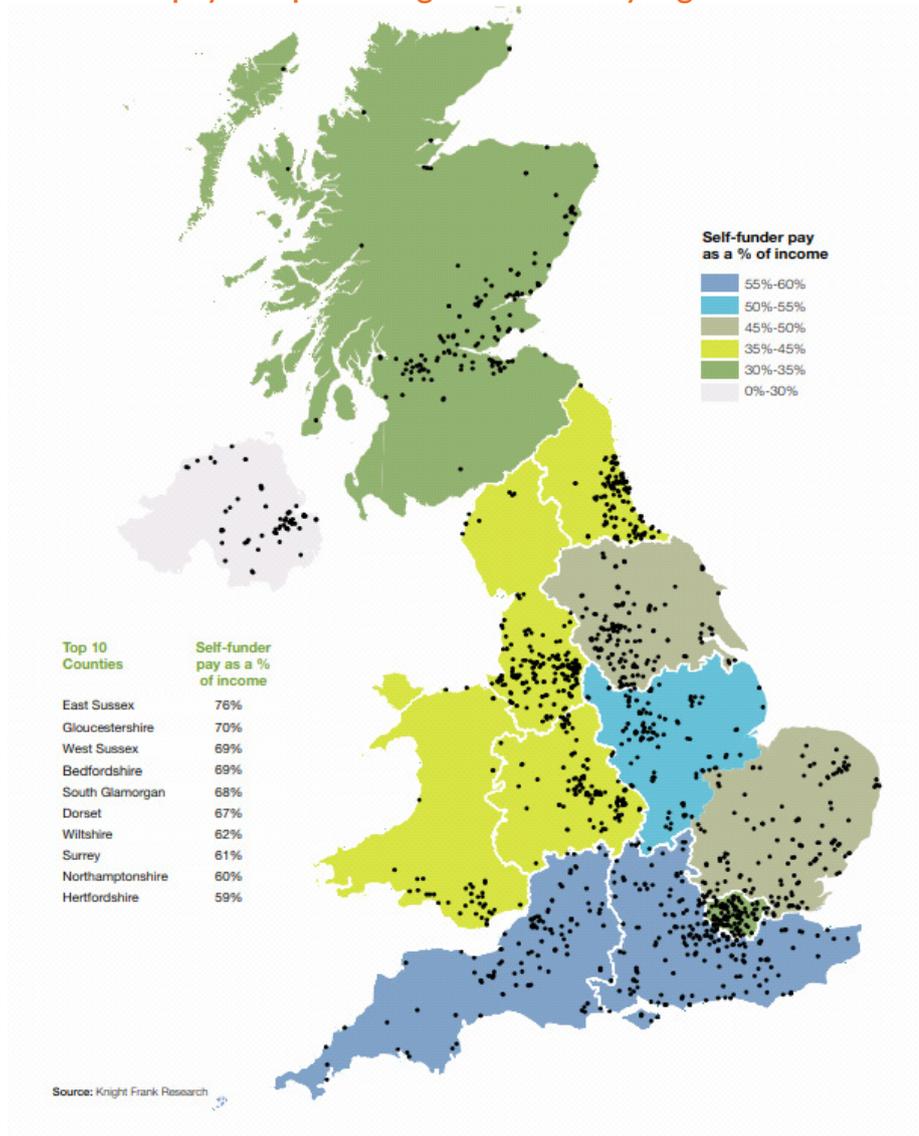
80. <https://www.gov.uk/government/publications/care-homes-market-study-summary-of-final-report/care-homes-market-study-summary-of-final-report>

tightly drawn, practically anyone who owns their own home is ineligible for state funding. Because of the present lack of transparency in the pricing differential, many self-funders do not yet realise that they are effectively subsidising places provided by the state out of taxable income and assets.

Region	Percentage of self-funders
North East	18%
North West	36%
Yorkshire and the Humber	42%
East Midlands	43%
West Midlands	39%
East of England	45%
Greater London	30%
South East	54%
South West	49%
Wales	24%
Scotland	30%
Northern Ireland and Isle of Man	16%
UK	41%

Source: CMA pp. 34, LaingBuisson Care Homes Surveys 2014

Self-funder pay as a percentage of income by region



Source: Knight Frank Research

The annual cost of care in the UK is £15.9 billion.⁸¹ The proportion of self-funders varies around the UK.⁸²

But wherever they live, they are subsidising an unfair system.

81. <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf> pg7

82. <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf> pg34

3. How we can solve the problems: policy

The Solution: publicly funded social care, financed by general taxation, with an affordable co-payment

Unless we are bold and imaginative enough to get to the root of the problems, there is a risk that social care will deteriorate further as successive governments fail to confront the central issue, which is the stringent means test combined with the lack of priority given to social care within public expenditure.

We need to ensure that the health and social care systems cohere and fund them adequately if we are to achieve the efficiency and confidence that will ensure a balance of demand and supply, universal fairness and give the care industry the ability to invest to raise quality and productivity.

How to fund it?

We should dismiss private insurance as a red herring. The King's Fund, in its survey of nine countries' arrangements for social care, concluded that most "do not have well-functioning private insurance markets to cover social care needs."⁸³ It notes that "where private markets have emerged they tend to be small and plans are expensive."⁸⁴

It is at best a niche market which sells the opportunity to jump queues for the treatment of one-off or acute conditions. It can do nothing for chronic conditions. The majority of the population of the United Kingdom ungrudgingly fund the NHS. Indeed, a majority show support for raising income tax or national insurance to pay for it.⁸⁵ We believe the same principle of free treatment for all, that underpins the health service, should apply to social care – which should be largely free at the point of use. There should also be a review of the assessment criteria for accessing care to ensure that there is consistency across the country in terms of the thresholds of need that are applied.

The present income and capital means test for complex social care should be ended. The capital component of the test should be eliminated and the means-testing charging regime, on income, should be changed into a limited co-payment regime of the order of £5,000 per person per year.

The new co-payment regime should be constructed so that no present user pays more than they pay under the current means-testing arrangements and all users of the service face a co-payment no greater than £5,000. Clearly,

83. King's Fund, The social care and health systems of nine countries, <https://www.kingsfund.org.uk/sites/default/files/media/commission-background-paper-social-care-health-system-other-countries.pdf> pp. 10

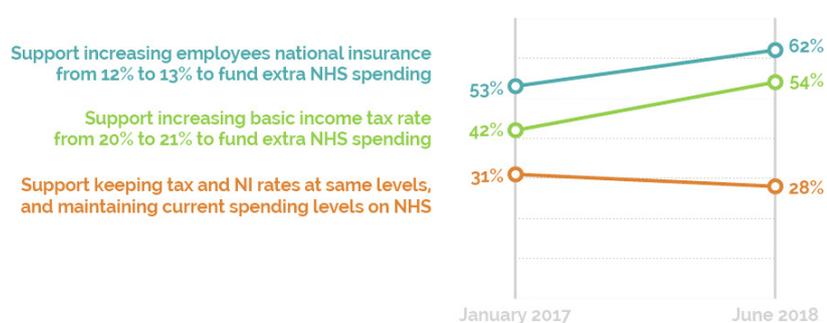
84. Ibid

85. <https://yougov.co.uk/news/2018/07/03/majority-brits-now-support-increasing-income-tax-f/>; <http://www.natcen.ac.uk/news-media/press-releases/2018/september/support-for-more-tax-spend-at-fifteen-year-high/>

this would not preclude additional private payments for extra services, as in the present social care regimes. As a basis for consultation, the starting point for the co-payment should be around one and a half times average annual pensioner income which is approximately £27,000.⁸⁶ Such an arrangement would avoid, for example, a pensioner whose retirement income is solely the state pension, or not much more, having to make the co-payment. There could also be discretion for the co-payment to be reviewed periodically after a person has been in receipt of care for five years.

One principal purpose of the co-payment is to stimulate the social care user's role as a consumer of the service and to invigorate the ideas that have informed the development of personal budgets. It is not intended as a mechanism for recovery of the economic cost of the service.

Support for raising income tax or national insurance rates to fund extra NHS spending has risen noticeably



YouGov | yougov.com

Latest data: June 24-25, 2018

It is for a government to decide what functions and roles it wishes to carry out and how generously it wishes to finance them. Expenditure can be funded by taxation or by borrowing, which is little different from delayed taxation and reflects a political community's preferences over timing of taxation.

In general, revenue should be raised from taxes that are as neutral as possible. Recurrent expenditure on programmes of spending that are likely to increase over time, such as social care for older people, need to be financed by sources of revenue that broadly increase as the economy expands. Taxes on property and capital are not only unpredictable but have proved deeply controversial, so in practice this means the taxes must be on flows of expenditure and income.

Economists tend to prefer taxing expenditure rather than income because it does not give rise to the double taxation of savings and investment income. And the use of national insurance rates is more distorting than income tax because it is in effect a payroll tax that reduces incentives to hire and supply labour. Further increases in payroll social security taxes should be avoided because the potential damage they do to employment.

Many people are attracted to the concept of hypothecating specific taxes to particular purposes, yet it makes little sense economically and would set a damaging precedent within the public finances.

86. Based on median weekly net income before housing costs in 2017/18, which was £344, DWP, 'Pensioners' income series: financial year 2017 to 2018, Table 2.1, <https://www.gov.uk/government/statistics/pensioners-incomes-series-financial-year-2017-to-2018>

Hypothecation and social care

Tax hypothecation – the ring-fencing of receipts from taxes to pay for specific items of public expenditure – is often discussed by policymakers in the context of health and social care funding. One 2017 survey from the King’s Fund suggested that as many as two-thirds of voters would be willing “to pay more taxes in order to maintain the level of spending needed” on the health service. As social care is a closely related priority, it is reasonable to assume that it would enjoy similar levels of public support. But is it a good idea? In practice, no – good politics can make for bad economics.

The difficulty lies in the fact that the level of required funding for a given spending priority will bear no relation to how much money a specific tax raises. There are good reasons why the government may choose to spend more money on social care, as this report explores. Under a system of tax hypothecation, however, it would be constrained by revenue collected from a specific “social care tax”. Receipts from individual taxes assigned to a particular spending programme over the economic cycle can be erratic (exemplified by feast and famine) which if reflected in spending would be unhelpful in carrying out the function in a manner consistent with efficiency, economy and effectiveness. The economic cycle would potentially offer a significant challenge. In the USA hypothecated taxes for Social Security and Medicare generate awkward debates about the whether these services will ‘run out of money’ at some stage, which is a distraction from the complex choices that need to be made about them such as their efficiency, scope and cost. It may be that too little would be raised in a particular year, for example during a downturn. In another year, too much might be raised – and why should the government not be able to divert those funds to other priorities, such as debt repayment or reductions in marginal tax rates?

Spending on social care needs to be determined in the way that other spending priorities are determined. Once a given level of expenditure is decided on, it should be financed through general taxation. In the main, recurrent public spending should be financed from a broad tax base of recurrent taxes on income and expenditure. These taxes should be constructed in a manner that is broadly neutral and imposes least deadweight cost on the wider economy.

An increase in social care funding could save the NHS money

The reason an increase in spending on social care could result in NHS savings was demonstrated by Age UK in 2017 when it calculated that four million hospital bed days had been lost since 2011 due to problems finding patients adequate social care. A hospital bed costs four times as much a day as a place in a residential care home, with an acute hospital bed costing between £2,089 and £2,532 a week compared to £519. Domiciliary care costs much less.⁸⁷

87. <https://www.ageuk.org.uk/latest-press/articles/october/four-million-hospital-bed-days-lost-since-2011-due-to-problems-securing-social-care/>

Unnecessary delay in the discharge of older patients is a longstanding issue. A 2016 NAO report that goes to the heart of the financial problem in the structure of care and its funding and charging arrangements observed: “Keeping older people in hospital longer than necessary is... an additional and avoidable pressure on the financial sustainability of the National Health Service (NHS) and local government.” It describes the damaging consequences of spending unnecessary periods in hospital, which can lead to declining physical and mental health and increased long-term care needs. Older people swiftly lose mobility and the capacity to carry out and manage basic everyday tasks such as getting dressed and washed.⁸⁸

Financial consequences for the future

The financial consequences of this will become more challenging in the years ahead. The NAO points out that the number of older people in England rose by 20% between 2004 and 2014, and is projected to increase by 20% in the decade to 2024. The number of emergency admissions of older patients to hospital increased by 18% between 2010-11 and 2014-15 and they now account for 62% of total bed days spent in hospital.⁸⁹ This means that admitting older people to hospital only when they need acute medical rather than domiciliary care, and ensuring that they can leave as soon as possible, will be central to containing NHS health costs.

Future costs of taxpayer-funded social care

The present system for funding social care and charging for it evolved from the 1948 National Assistance Act. The UK is now a much wealthier society, and better placed publicly to finance long-term care in a way that would end the perverse consequences of the present, defective, inadequate funding arrangement. As Sir Andrew Dilnot said forcefully: “There’s plenty of money... GDP in real terms is more than 5.5 times as big as it was in 1948... We may choose not to afford it but the notion that we can’t afford something, given what has happened to our income, is striking and quite surprising, and doesn’t strike me as correct.”⁹⁰

For illustrative purposes, in revenue terms, 1p on the basic rate of income tax yields £4.5 billion in 2020/21, or 1 percentage point change in the standard rate of VAT yields slightly over £6.6 billion in 2020/21.⁹¹ Income tax relief for registered pension schemes is worth £24 billion in tax⁹² – these are just some of the examples of the choices Governments have made. It is a significant yet far from unaffordable addition to the public expenditure bill. The costs involved are manageable within UK general government expenditure of some £840.7 billion⁹³ and an economy that generates over £2,200 billion of income annually.⁹⁴

The following costings, moreover, take no account of the potential savings that would result from a coherent integration of social and health care.

88. <https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital-Summary.pdf> pg3

89. <https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital-Summary.pdf> pg3

90. <https://www.theguardian.com/society/2017/apr/06/andrew-dilnot-social-care-reviewer-condemns-uk-system-and-calls-for-new-tax>

91. HMRC, Direct effects of illustrative tax changes, April 2019, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/797042/190424_SS19_Direct_effects_of_illustrative_tax_changes_BULLETIN_FINAL.pdf

92. <https://www.aon.com/unitedkingdom/employee-benefits/news/articles/cost-of-pension-tax-relief-to-reach-24bn.jsp>

93. OBR, Economic and fiscal outlook, March 2019, Table 1.2, p12, https://cdn.obr.uk/March-2019_EFO_Web-Accessible.pdf

94. OBR, Economic and fiscal outlook, March 2019, Table 3.10, p67, https://cdn.obr.uk/March-2019_EFO_Web-Accessible.pdf

Costings

Given demographic trends, merely maintaining the current system of self-funders and local-authority funded residents will result in additional public (and private) spending. So there needs to be an estimate of future costs to maintain the current system and the additional spending that would be required for social care to be fully taxpayer-funded.

Future demand

Inevitably there is a high degree of uncertainty about future demand for, and costs of, social care. Based on ONS data, there will be around 1.9 million over 85s – the main age group in care homes – in the UK by 2025.⁹⁵ But the proportion of these that will require residential care is less easy to predict. The majority of those entering residential care have a disability so that judging the likelihood of this among the over-85s is important and gives rise to a range of estimates. Another factor is the potential for greater use of technology, including robots, that may allow people to continue to live at home when previously a care home would have been the only option. This is explored in the following section.

The CMA report concludes that the UK care home population will grow by between 1.4% and 2.9% annually between 2015 and 2025 – a rise of between 63,000 and 119,500.⁹⁶ The current equivalent for England is between 34% and 64% over that period, or 53,000 to 100,000.

Additional uncertainty applies to projections of costs per resident. Labour costs are about 50% to 60% of the total costs of running a home, and workers are paid at or close to the National Living Wage (NLW) introduced in 2016. The government's declared aim is for this to reach 60% of median earnings by 2020.

Current costs

The current system involves cross subsidy between care-home residents paying for themselves and those who are funded by their local authority.⁹⁷ This cross subsidy can be significant: on average a self-funder's place costs about 41% more than one paid for by the local authority.

For England, the NAO estimates around £20.4 billion was spent in 2016-17 by local authorities on adult social care.⁹⁸ As discussed, that includes: £14.8 billion net spending carried out directly by local authorities from their social care budgets; £2.7 billion of user contributions to local authority-arranged care, from those who fall above the lower limit of the means test but below the upper limit – i.e. those who, in England, have assets (excluding their home and pension) between £14,250 and £23,250; £2.6 billion local authorities receive from their local NHS Trusts for care which forms part of the social care package, but has to be carried out by medical staff who are not social care workers, such as nurses. Local authorities are not under statutory duty to provide and commission those services, as that is the role of the NHS Trusts. Where those services are required as part of social care, it is the NHS Trust which covers the cost, not the local authority. Finally, the NAO also gives £0.3 billion of income

95. <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf> pg7

96. <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf> pg83

97. <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf> pg41

98. NAO, Adult social care at a glance, July 2018, p10, <https://www.nao.org.uk/wp-content/uploads/2018/07/Adult-social-care-at-a-glance.pdf>

for local authority arranged care from other sources.

On top of the £20.4 billion accounted for above, around £10.9 billion is spent by self-funders – individuals who fall above the upper limit of the means test by having assets (excluding their home and pension) in excess of £23,250.⁹⁹

Cost estimates of introducing free personal care

A recent report by the King's Fund estimated that an extra £7 billion would be needed by 2020-21 compared with 2015-16 to fully fund personal care by the state, rising to £14 billion by 2030-31.¹⁰⁰ However, it also estimates that the extra resources needed just to maintain the current system in future years would reduce the marginal cost of “free” personal care to £6 billion in 2020-21 and £8 billion in 2030-31.¹⁰¹ Alternatively, the NAO estimate of the total amount spent by self-funders - £11bn in 2016/17 – may be taken to be an approximation of costs that the state would need to take on.¹⁰²

These sums are clearly not trivial, but they are manageable. The required additional resources, taking the upper estimate of £11bn, amount to around 0.5% of GDP or 1.3% of total public spending, or 0.3% of GDP and 0.8% taking the lower King's Fund projection of £7bn shortfall in 2020/21. This shows that addressing the fundamental issues in relation to social care is manageable and tractable within overall UK public expenditure and national income.

Affordability

It is not for this study to suggest how the 0.5% of GDP might be funded, but we can agree with Andrew Dilnot that it is entirely within the means of a rich society like the UK to do. The particular context in 2019 has been a decade of tightly constrained increases in public expenditure, popularly known as “austerity”, following the banking crisis of 2008-9. During the crisis years public spending rose rapidly and was subsequently squeezed.

By 2018 spending had fallen to 38% of GDP compared with 46% in 2010. The volume of service provision did rise, albeit slowly, as the main cost, public sector wages, stagnated in real terms. As outlined above, cuts fell particularly hard on the social care budget. However, austerity can now come to end since the public sector deficit has fallen to 1.5% of GDP and has been below 3% of GDP for three years. The net debt of the public sector has also begun to fall from its peak of 86% of GDP. Current OBR projections for real government current spending suggest growth at under 2% per annum for five years leading to a ten-percentage point reduction in net debt (to 74% of GDP). This steep reduction in debt is a policy choice and one that would be only slightly affected by an increase in spending on social care of 0.5% of GDP. Higher taxes or spending cuts elsewhere would be alternatives but a slower reduction in debt is a sustainable approach.

99. Ibid.

100. King's Fund, Social care funding options: How much and where from?, May 2018, Table 0.1, p7. <https://www.health.org.uk/sites/default/files/Social-care-funding-options-May-2018.pdf>

101. Ibid.

102. NAO, Adult social care at a glance, July 2018, p10, <https://www.nao.org.uk/wp-content/uploads/2018/07/Adult-social-care-at-a-glance.pdf>

The limitations of insurance

There is a significant modern economic literature that has explored the limitations of insurance markets. In 2001 three economists – Joseph Stiglitz, George Akerlof and Michael Spence – shared the Nobel Prize for their exploration of the imperfect information that lies behind these limitations. In practice, this means that private insurance is not available for either health or social care in old age at a reasonable and affordable cost for most households. Insurance markets can provide cover for discrete episodes of risks but not for recurrent events or chronic conditions, such as long-term social care. Social care in old age is a risk that can only be properly covered, at a realistic cost, by collective public provision paid from taxation. That is the rationale for the state taking on collective responsibility for financing social care.

Insurance markets are constrained by several issues that result in insurance companies managing their liabilities to contain costs that they cannot reliably foresee and have the potential to bankrupt the insurer. These are asymmetries of information between the insurer and the customer seeking cover. A person seeking insurance will have a better sense of whether they will need cover than the insurance company providing it. They will have a better purchase on their family history and a clear knowledge of their own behaviour in relation to lifestyle. This asymmetry of information confronts that insurance provider with the challenge of adverse selection. The people most likely to need the cover seek to take it out, so that the population paying for insurance does not reflect the average distribution of risk, but the minority that were more likely to use it.

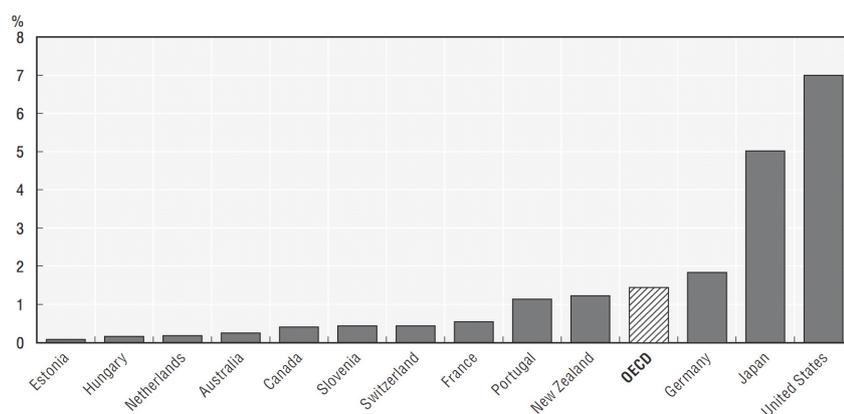
Once people have paid for an insurance policy there is a tendency to want to use it. This determination to use an insurance policy once taken out exposes insurance companies to the risk of being subject to moral hazard. This risk of moral hazard is aggravated by a tendency for providers of services to over-provide and charge more when they know that there is a third party payer, who will foot the bill. This gives rise to moral hazards that insurance companies have to take account of in their pricing of risk. Asymmetries of information, adverse selection and moral hazard combine to make insurance cover for medical and social care expensive. Insurance companies respond to these problems not only by raising the price of insurance, but by developing rules and exemptions that enable them to refuse to cover costs.

Private long-term care coverage in OECD countries covers a very small share of the cost of care. Long-term care insurance is principally sold in the US and Japan where it finances between 5 and 7 per cent of long-term care expenditures. But in general, private insurance accounts for less than 10 per cent of long-term spending. The OECD paper *Private Long-term Care Insurance: A Niche or a "Big Tent"?* explains that these sorts of insurance products have tended to develop around a country's publicly funded long-term care system either to complement available public coverage, or to provide benefits where there is no public provision. In Germany, private insurance offers substitute insurance cover to that part of the population that opts out of public long-term care insurance. In the US, most of the buyers of long-term care insurance are not eligible for Medicaid, which targets low-income households – albeit generally exempting the main home from the capital aspect of the means test.

The limitations of insurance

The private LTC insurance market is small

Share of total LTC spending



Source: <http://www.oecd.org/els/health-systems/47884985.pdf> pp. 248

The King's Fund, in its survey of nine countries' arrangements for social care, concluded that most countries "do not have well-functioning private insurance markets to cover social care needs."ⁱ It notes that "where private markets have emerged they tend to be small and plans are expensive."ⁱⁱ

It is difficult to avoid the conclusion that private long term care insurance will, at best, be a specialist or niche market, and would represent a less efficient and more costly way of providing universal and comprehensive coverage, relative to the public pooling of risks through collective provision.

i. King's Fund, *The social care and health systems of nine countries*, p10, <https://www.kingsfund.org.uk/sites/default/files/media/commission-background-paper-social-care-health-system-other-countries.pdf>

ii. Ibid.

4. How technology can help

Background

There is a general appreciation that technology, big data and artificial intelligence will radically change the way that goods and services are provided and the character of employment. Until recently, most people thinking of the future role of technology and jobs would have been confident that one area that would be immune from these changes would be roles involving personal social care. There are, however, now accumulating examples demonstrating the practical way that technology can make a contribution to areas such as social care. This includes the monitoring of people, the management of medication and the management of matters such as incontinence. Technological innovation has the potential both to improve care in domiciliary settings and in residential care settings. It may help to contain some of the costs that are involved.

Areas in which technology will have or is already having a practical effect globally are: the integration of information and services; remote monitoring; assistive technologies (often targeting patient mobility); medication management; information provision and training; cognitive training and therapy and mental health.^{103,104} Countries such as Japan and Norway are pioneering the use of such technologies to enhance care and these technologies are so far proving beneficial to both care workers and care recipients, as well as leading to efficiency gains and potential cost reductions over time.

Japan

Due to its rapidly ageing population and a severe shortage of migrant labour, Japan is a leader in the adoption and development of care technologies. According to the Japanese Ministry of Economy, Trade and Industry, increased investment in and wider use of care robots is a government priority – especially in the areas of lifting aids, mobility aids, smart toilets, monitoring and communication systems, and bathing.¹⁰⁵ The Japanese government are also keen to see innovative Japanese technologies tailored to social care to thrive in its export markets.

At the start of 2018, care robots designed to lift and transport patients had been rolled out to 8% of Japan's nursing homes.¹⁰⁶ While humanoid robots specifically aimed at mobility assistance specifically are still rare and many (such as Robear) remain in their testing phase, less anthropomorphised robots are becoming increasingly widespread. The Reysone – a bed that detaches and transforms into an electric wheelchair

103.<https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/informatics/transforming-care-through-technology>

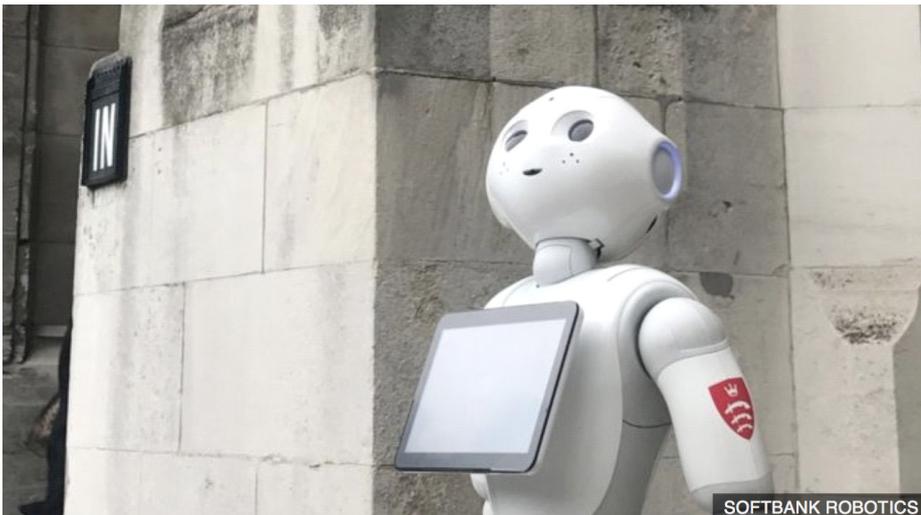
104.<http://www.ifa-fiv.org/wp-content/uploads/2012/11/som-2012-ltc-and-technology-final-report.pdf>

105.http://www.meti.go.jp/english/press/2017/1012_002.html

106.<https://internetofbusiness.com/robots-japan-social-care/>

– is one such machine.¹⁰⁷ Another mobility robot is TREE – the Assist Robot for Walking Rehabilitation – which offers balance support and fall avoidance by showing users where to place their feet.¹⁰⁸ Mobility-enhancing exoskeletons are also being developed as an alternative to such robots. Cyberdyne Inc’s Hybrid Assistive Limb (HAL) is used in a number of Japanese healthcare institutions. The HAL Lumbar Type model is specifically designed to provide “powered back support” to enable carers to lift and transport people with greater ease.¹⁰⁹¹¹⁰ In addition, the potential for directly fitting patients with such external devices in order to enable movement and aid physical rehabilitation is currently being tested.¹¹¹

It is also common for robots to be used for general assistance/therapeutic purposes. Pepper is a humanoid general-purpose robot thousands of which are deployed in around 500 Japanese care homes. Pepper provides basic conversation as well as assisting with various exercises and games. The use of robots for actual social interactions might risk alienating patients, yet care recipients in Japan have reacted positively to their introduction.¹¹² In a similar vein, Paro – a furry seal-like robot – has been deployed across the country and is increasingly accepted as an effective therapeutic aid.¹¹³



Pepper – a “culturally aware” robot – was designed to assist with the care of older people

Norway

Norway has embraced innovation in social care, but has focused less on robotic assistants and more on straightforward technological modernisation in the form of remote assistance and monitoring solutions. With respect to integrated patient data, the Norwegian Directorate of eHealth has already introduced an integrated digital national database of health records that can be accessed across the health and care sector as well as by patients.¹¹⁴ The Norwegian government has also prioritised the national rollout of “telemedicine, e-health and welfare technology” – a priority enshrined in the National Program for Personal Connected Health and Care. Launched

107.<https://www.reuters.com/article/us-japan-ageing-robots-widerimage/aging-japan-robots-may-have-role-in-future-of-elder-care-idUSKBN1H33AB>

108.<https://shinkachi-portal.smrj.go.jp/en/navi/company/p1tvk/3nm6n/>

109.lbid

110.https://www.cyberdyne.jp/english/products/Lumbar_CareSupport.html

111.<https://www.ncbi.nlm.nih.gov/pubmed/26511112>

112.<https://www.japantimes.co.jp/news/2018/03/30/national/robots-making-inroads-japans-elder-care-facilities-costs-still-high/#.W21wGM5KiUk>

113.<https://www.agedcareonline.com.au/2015/01/PARO-The-Therapeutic-Robot-Helping-The-Elderly>

114.<https://www.accenture.com/us-en/success-norwegian-directorate-ehealth-electronic-health-records>

in 2013, this programme led to the introduction of tech-supported care in 34 municipalities with the ambition of having a fully integrated tech-supported care system by 2020.

In terms of ‘in-house’ technology, the programme has involved the introduction of the following: personal alarms; electronic drug dispensers and medication adherence systems (known as Pilly) that tell patients when and what medication to take, as well as informing carers when a patient is not taking their medication as they should. Norway has also distributed various monitoring solutions and remote care assistance products that vary according to each recipient’s health needs (e.g. weight scales, temperature readers, blood pressure monitors, pulse oximeters, spirometers, blood-glucose meters, and regular clinical questionnaires). Health values are routinely monitored remotely by carers who can intervene/check-up on patients through digital channels (e.g. voice/video call) if necessary. The records can also be accessed by care recipients via the MyDignio smartphone app, as well as forwarded onto relatives.¹¹⁵

In Oslo (where the programme was rolled out in early 2014) results have generally been positive. Users reported a greater sense of ‘presence’ of community nurses as a result of digital check-ups and communication. Others claimed that being able to access their health values easily enabled them to “recognise their own body signals and plan... better” as a result.¹¹⁶ The programme also had clear knock-on benefits on health and social care from a public policy perspective. After 6 months of the rollout of the programme, outpatient appointments for care recipients fell by 34.3 percent, hospital admission by 18.7 percent, and hospital bed days by 33 percent.¹¹⁷ Nursing home-care visits similarly fell 34 percent as did the duration of visits (a decline of 31.5-59.3 percent).¹¹⁸

Europe and the UK

Western Europe has been relatively slow at adopting new care technologies when compared to places such as Japan. However, several companies – typically with EU assistance – have piloted a number of schemes that highlight the potential of technological innovation in telemonitoring and smart-home technologies in improving care and co-ordination. France’s Limousin Region piloted an automated ‘Advanced Telecare’ home care system that assisted with independent living at home through the use of various instruments such as light paths and sensors that helped prevent falls and other accidents. The system was also connected to a bracelet/pendant worn by the individual that could be set to automatically contact the relevant carer/relative when it appeared that help might be required.¹¹⁹ In the Basque Region of Spain *Telbil* – a telemonitoring service for those in receipt of primary care for chronic conditions – was deployed. Its principal recipients were those with chronic heart and lung conditions who have difficulty leaving their homes for check-ups/ treatment. *Telbil*’s monitoring component connects to the care recipient’s smartphone, records the patient’s health data and sends it on to a web manager where health professionals can access it. By monitoring patients’ health in their

115.<https://helsedirektoratet.no/Documents/Velferdsteknologi/The-personal-connected-health-and-care-in-central-Oslo-project-2016-10-VIS-report-in-English.pdf>

116.Ibid

117.Ibid

118.Ibid

119.<http://publications.jrc.ec.europa.eu/repository/bit-stream/JRC96022/Ifna27256enn.pdf>

own home, the need for physical check-ups was removed and early signs of deterioration could be observed, enabling comparatively earlier – and thus more effective – interventions if needed.¹²⁰

Various public and private sector organisations in the UK have indicated an appreciation of the potential impact of ‘smart-care’. An Accenture Pilot programme in London showed the promising benefits of monitoring data coupled with the use of AI to monitor the big-data that was produced. In this scheme, AI and monitoring technologies were used in tandem to learn the behavioural patterns and care routines of elderly people, helping them to manage their own care and stay in their own home as long as possible as well as informing professional carers and relatives of anomalies and where indicators suggested the patient was in need of assistance.¹²¹ There are in addition incipient moves towards Japanese-style care modernisation through the use of robots. Advinia Health Care for example recently announced a £2.5million EU-funded trial of Softbank’s Pepper robot in its care homes, which started in September 2018.¹²² Nevertheless, despite some positive examples of a willingness to embrace technological innovation in social care, the role of tech in UK social care remains in its infancy and there undoubtedly remains much more to be done.

Overall, evidence from international case studies and pilot schemes suggests that technology that is designed well, that receives the right sort of governmental encouragement and that is competently delivered can improve and enhance patient welfare and autonomy. It can assist carers (both professional and informal carers) by making the care model more efficient and flexible, and – despite initially high costs of developing and introducing technology – may result in efficiency gains to social care with long-term fiscal benefits. As in any public policy area, it would be wrong to assume that technology is a panacea. The evidence available suggests that the appropriate public policy could stimulate innovation in the UK and could yield significant dividends in a number of fields.

The UK is a leader in the field

In its 2018 report, *The Smart State: Redesigning government in the era of intelligent services*, Policy Exchange explored the underlying principles and benefits of the UK’s continued digital transformation journey towards “government as a platform”.¹²³ It was an approach endorsed by Francis Maude, former Cabinet Office Minister principally responsible for the creation of the Government Digital Service (GDS), and provides a solid foundation to build on as we look at how long-term improvement in social care can be significantly helped by the HealthTech sector.

The digitalisation of the Government Digital Service (GDS) has been steadily gaining pace. Recent research from Tufts University in Massachusetts identified the UK as the world’s most balanced, digitally evolved nation in the world.¹²⁴ Technological advances should change almost every aspect of health and social care in the near future. High quality medical care should become cheaper and more readily available worldwide along with the licensing and proliferation of new medicines and fundamentally new

120. <http://publications.jrc.ec.europa.eu/repository/bitstream/JRC96022/1fna27256enn.pdf>

121. <https://newsroom.accenture.com/news/accenture-uses-artificial-intelligence-to-help-the-elderly-better-navigate-their-care-and-improve-their-well-being.htm>

122. <http://www.carehomeprofessional.com/advinia-health-care-announces-robot-care-home-pilot/>

123. Policy Exchange, *The Smart State*, 2018, <https://policyexchange.org.uk/wp-content/uploads/2018/05/The-Smart-State-1.pdf>

124. The Fletcher School, Tufts University – Digital Planet 2017, p.35: https://sites.tufts.edu/digitalplanet/files/2017/05/Digital_Plant_2017_Final.pdf

models for service design and delivery.

The potential should not be underestimated. The scale and transformational benefits of technology for healthcare services are already visible today in OECD HealthTech pioneers like the UK and the US. As in other aspects of technology, such as banking, examples of innovation are offered from the experience of developing economies. A good example is Rwanda, which faces labour force challenges arising from a lack of doctors and trained professionals in jobs ancillary to medicine.

Where is the UK in relation to health technology?

Over the past two years the NHS has made some progress in developing its digital transformation plans and embracing technology with a view to delivering better patient care more efficiently, with greater flexibility and more control for patients.

Examples of recent initiatives include:

- **The new NHS Digital Platform** - a central resource with access to huge quantities of data made publicly available
- **Beta release of NHS Apps service** - a central portal to help patients find health targeted apps and related services
- **Digital Patient Records** - a commitment to ensure everyone can gain access to a digital copy of their patient records
- **NHS App** - plans to launch an app to give patients such facilities as booking appointments and seeing test results

In practice, the NHS is continuing to catch up on technological opportunities that private practitioners have been using for some time. HealthTech firms are filling gaps in NHS services, but have not reached their true potential. For example:

- **Babylon** offers patients free access to their AI-powered chatbot “GP”, easier access to “non-local” GP services for a small monthly fee and allows people to bypass their GP entirely and pay around £40-£50 for a video consultation directly with a specialist, removing the need to get a referral from a GP.
- **Push Doctor** provides a video-chat based remote GP service, with significantly decreased waiting times for an appointment, greatly expanded opening hours and a more streamlined integrated process for patients to collect prescriptions locally.
- **Echo** is entirely focused on helping patients manage their medication, with an app that offers a simple way to arrange, pay for and collect both new and repeat prescriptions without needing to call the original GP or specialist consultant.

From the perspective of the users of the service, the emergence of this type of HealthTech app has improved the quality and flexibility of care people could receive from the NHS. However, many of the most popular

HealthTech apps offer examples of the most basic opportunities that illustrate the potential there is to apply technology in this area.

The NHS should be able to stimulate HealthTech innovation in social care

Government should give the NHS greater autonomy over how it uses and influences the development of HealthTech to encourage the sector to grow and innovate. This will ensure that the resulting products, services and successful firms will integrate with the NHS system, delivering the maximum benefit and improvement of social care for patients.

How HealthTech could improve the NHS delivery of social care

- **Improving real time “patient-led” monitoring** and facilitating basic self-administered treatment for those in social care to allow them to remain in their homes and enjoy a higher quality of life.
- **Providing increased patient choice and streamlined access to the care system**, as well as offering greater flexibility and control via an opt-in model for new “innovative” social care services, potentially delivered in partnership with the NHS.
- **Improving the quality of life for people in social care**, both for those in-home care facing loneliness and isolation, as well as for patients that are best cared for in a residential setting.
- **Addressing unfairness and lack of security within social care**, using advances in AI machine-learning, open data platforms and modern cloud-based backend IT systems to better coordinate commissioning and planning at a local level, yet with benefits of scale.

For example, a theoretical HealthTech App for elderly people that used AI to monitor a person’s daily movements and routines around their house, offers the opportunity to reduce the need for carers and makes it possible for emergency services to respond more quickly in the event of a patient falling or suffering a sudden and acute health episode.

How HealthTech could improve the quality and contain the costs of care in a person’s home

- Self-administered treatment of more conditions at home
- AI-assisted remote monitoring of patients and their condition
- Remote care-workers and medical assessments

Remote monitoring and quicker assessment of crisis situations

A key service provided by in-home care workers is both the regular monitoring of healthcare and administration of regular treatments. Where appropriate, HealthTech innovation can remove the need for the physical presence of a care worker, even in cases where a patient might be suffering

from conditions that present particular challenges and risks in terms of ensuring a patient takes regular measurements of their own vital signs and the correct dosages of medication.

Wearable devices are already becoming increasingly popular among younger people - either in the more limited form of monitoring daily activity and levels of physical movement, or the more advanced capabilities of devices like the Apple Watch that are able to measure things like heart rate. The potential to improve the quality of social care of patients is when wearable devices are complemented by remote human monitoring and AI machine-learning, which can “learn” to detect warning signs based both on a patient’s individual measurements and that of entire cohorts of similar patients with similar conditions.

However, the potential for more advanced wearable devices is greater still and could remove the need for many visits to hospitals that elderly people currently undertake, which have significant costs and stretch the resources of NHS services. A startup firm in California called Openwater is developing a “wearable” MRI device, that fits inside a simple hat and is capable of scanning the brain with a resolution much higher than that of traditional MRI machines. And as Babylon’s automated AI-powered chatbot diagnostic service shows, when advanced medical devices are coupled with AI machine learning, the results offer extraordinary possibilities.

For example, sensors installed in houses can be used to monitor patients and build up a profile of their typical daily routine in order to detect any anomalies – such as failing to turn on lights and kitchen appliances in the morning to prepare breakfast. This type of 24-hour data collection can provide an even richer “diagnosis” of the patient when combined with data from devices worn by the patient themselves to monitor key vital signs such as heart rate, blood pressure and overall level of movement. However, it should be noted that even the most advanced sensors are only capable of recording data and the most well “trained” AI machine learning systems based on data from millions of patients, can do no more than complement human care.

AI systems and sensors cannot physically respond to a medical crisis and actually help a patient in the event that something goes wrong when they are alone at home. Yet an AI device could detect warning signs of a patient suffering a heart attack or even depression and loneliness much better than a face-to-face assessment made as part of a routine daily or infrequent “check-up” visit by a rushed carer. Greater investment in innovative new HealthTech combined with the overall improvements in the quality and scale of social care has the potential to improve the UK’s current social care provision.

Streamlined access to the care system

The principal issue that technology can address in the short term is to simplify the labyrinth of choices available to service users via a single interactive centralised platform of information about the care system. Gov. UK has been recognised internationally for its progress towards the digital transformation of government services, with a variety of interactive tools

helping guide people towards the most pertinent information and helping them access services online.

As interactive tools are used on Gov.UK to guide people in regard to whether they are eligible for certain benefits or whether they are required to file a self-assessment tax return, these principles and technologies can be adapted to helping people navigate the social care system.

Easier access to information through a GDS-linked ‘MySocialCare’ app

The GDS should be asked to explore the potential of an interactive “My Social Care” platform that would be available to all persons in receipt of social care – as well as their relatives, friends and social care workers – and could be accessed either at home, or with assistance during the normal care assessment process conducted by councils.

The purpose of the app would be twofold: first, assessing the care needs and relative priorities patients themselves have. For example: would they prefer to be cared for in their own home, or in a care home? Second, it would collect information about the circumstances of the patient, and on that basis, inform them of what options are available to them. Given the administrative burden social care provision places on the patients and their families, this would be a significant, positive step towards alleviating it.

The government needs to think long-term and imaginatively

The rapid pace of innovation seen in areas like AI – where diagnostic chatbots can now outperform human physicians – or in the coordination and improvements in the quality of home care services through the use of cloud-computing and remote monitoring of patients, show that there is huge potential to improve the quality of care, choices and efficiency.

It was somewhat discouraging that while the NHS spent £150 million on upgrading IT systems in direct response to the WannaCry ransomware attack, it very recently announced a fund of just £1.8 million spread across 18 local authorities that wanted to pilot innovative social care HealthTech initiatives. Government has an obvious choice between helping to foster technological innovation incrementally or approaching it in a more systematic and ambitious manner.



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