STABLE FOOTING

Ensuring a sustainable future for social care

By Paul Saper and Eamonn Butler

BRIEFING PAPER

EXECUTIVE SUMMARY

THE PROBLEMS

- Although the existence of the future funding crisis in adult social care is widely acknowledged, its scale is greatly underestimated. Factors in supply and trends in demand both fuel this crisis.

- On the demand side, the demographic trends are understood. But care budgets cover not only the needs of the elderly; they also the needs of younger people with physical and intellectual disabilities, whose numbers are increasing.

- More women participate in the economy, making it harder for them to care for relatives. Many family carers are themselves elderly and limited in what they can do. And families are more dispersed, with fewer people living near their elderly relatives. Meanwhile, inefficiencies and perverse incentives force more people with social care needs onto the NHS, leading to unsustainable budget pressures.

- On the supply side, it is difficult to induce people to save for something that only one in four of them will need. And insurers are unwilling to step in because of the 'long-tail' risk that some individuals may need many years of expensive care.

- The system is a lottery and widely perceived as unfair. The old mechanism by which self-pay residents subsidised public provision is, increasingly, no longer working.

- Care at home often flouts employment and wage legislation, and many of those hired as live-in carers have low skills and few qualifications, risking poor quality care. A crackdown on this seems inevitable, meaning that other care options will have to be provided

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- Nearly all care homes with local authority-funded residents are at least 20-25 years old and no longer up to standard. We need a new mechanism to encourage pension funds, insurers and other long-term investors to invest in this segment of the market. If this were combined with efficient management delivered by independent for-profit or non-profit providers, chosen by the investing institutions and the local authorities, the latter would have access to lower-cost and better-quality provision than is currently available and allow them to phase out obsolete stock.

- We recommend that government creates the conditions for a long-term care insurance market by the state agreeing to pick up the long-tail costs of those who insure themselves after, say, six years. This would make insurance products viable and affordable so that individuals would be able to pool their risks and insure themselves, just as they do in other areas of life. Moreover, bringing in the insurance sector would bring more order into the market, as the insurers would be responsible for meeting the costs.

- At present, care at home is contracted on the basis of hours or number of inputs, with the focus on price rather than outcomes, and with no encouragement to integrate health and social care. This cannot continue in its present state and local authorities should look in future to contract with the new providers (who are waiting to come to the UK) who have developed technology platforms and more sophisticated caregiver recruitment, along with training plans that are the stuff of transformational change. Developing insurance products for long term care will also be a catalyst for network building and increased use of technology in this sector. We foresee that commissioners, who currently know what they are getting elsewhere in terms of quality standards, will want the same level of knowledge for the home care sector.

- Older people enjoy a number of benefits, from free TV licences and Winter Fuel Payments, to lower rates of National Insurance before they reach pensionable age. These, and the pensions Triple Lock, should be reviewed, and the Personal Income Tax Allowance adjusted, so that older but wealthier people make more of a contribution to their generation's care costs.

- A more rational and affordable care system will involve disrupting the market, but deliver greater supply, sustainability and fairness. Tinkering with the present system will not solve the looming crisis. What we need are new partnerships in a new market.

1. INTRODUCTION

As daily news reports make plain, UK local authorities' adult social care budgets are under growing pressure. The Chancellor, in the March 2017 Budget, sought to ease the pressure with a £2bn funding boost (£1bn in 2017 and then £0.5bn in the next two years), but critics complained that this was a short-term and insufficient fix and families who have to fund long term care themselves are finding it increasingly costly and hard to do so. However, the government also promised a Green Paper on social care as part of a public consultation and plans to publish this before Parliament's 2018 summer recess in July—its aim being to "ensure that the care and support system is sustainable in the long term" and to improve integration with health and other services and between different care providers. During the 2017 General Election campaign, the Prime Minister said the proposals would include a lifetime "absolute limit" on what people pay for social care, though there is less agreement on how this would work, how much it would cost, and how it would be funded.

However, there are limits to how far one can successfully achieve the aim of making social care costs sustainable by merely tinkering with the present system. We need a radical re-think about how social care is provided and funded, in both the public and the private sector. To be genuinely sustainable, reform will have to be disruptive.

2. TYPES OF SOCIAL CARE

A contributing factor to the strain on local-authority budgets, often left undiscussed in the public debate, is that care budgets currently cover the needs of not just the frail elderly and people with dementia, but also the needs of young physically disabled persons and people with development and intellectual disabilities (PLDs).

This group has seen a significant increase in numbers over the past two decades as their life expectancy has increased, with many PLDs now reaching 90% of the national average life expectancy. Simultaneously, the number of PLDs living in institutional settings has been increasing by 3-4 per cent annually, as their ageing carers (often their parents) find it increasingly difficult to carry on their caring role once they reach pensionable age. Local authorities have also had to take on the cost of PLD service users who were previously funded by the NHS in long-stay hospital beds, which has added to the challenge.

Although the number of older people looked after by government agencies has declined over this period, due partly to tighter rules on needs assessment and the greater wealth of the 'baby boomer' generation, these trends are changing in ways that are increasing the strain on budgets. The baby boomers are themselves starting to need support, families are saving less, and immigration and rising birth rates are raising the demand for schools and other services that compete for local authority funding. As saving becomes more challenging for families whose incomes are

flatlining, and as the cost of care rises, the prospect of paying for their own care or for their dependents' care is formidable.

The local authority funding challenge, in other words, is much greater than is often realised. And there are other trends that pile on the pressure too.

3. DEMOGRAPHICS

On the demand side, the demographic trends are worrying. Between 2006 and 2016 the total number of people aged 65 or over in England has risen more than 2.2 million, partly because fewer people now die before they reach pensionable age. Today the figure exceeds 11.8 million, around 18% of the population.[1] Meanwhile there are 285 people over 65 years of age for every 1,000 people aged 16 to 64. The greatest percentage growth is among those 85 years of age and over, who now number over 1.6 million.[2]

Another key statistic is that more than 2 million people aged 75 and over, mostly women, now live alone.[3] Today, a woman aged 65 in England can expect to live another 21.2 years, while the figure for a man is another 18.8 years: both have added more than a year in life expectancy in the last ten years.[4] But disability-free life expectancy has changed little: the figure for a woman is just 10.9 years, and for a man just 10.3 years.[5] These extra years of life are mostly lived with significant health problems.

Moreover, against expectations, huge variations still exist between people who are well off and those who are not. On average, better-off people expect to live nine years longer than people living in deprived areas. The gap between better-off and worse-off women living disability-free also remains high, as much as 13 years in extreme cases.

4. SOCIAL TRENDS

Social and demographic trends add to the funding challenge. More women are in employment today than fifteen or twenty years ago: so, they face a significant opportunity cost by staying at home to care for aged parents or other family members. If women do stay in work, there is little chance that their earnings will stretch far enough to provide high quality live-in care. Live-in care can cost upwards of £600

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1 Later Life in the United Kingdom , Age UK: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/later_life_uk_factsheet.pdf

2 Overview of the UK population: July 2017, ONS: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/july2017

3 Later Life in the United Kingdom , Age UK: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/later_life_uk_factsheet.pdf

4 Health profile for England : https://www.gov.uk/government/publications/health-profile-for-england/chapter-1-life-expectancy-and-healthy-life-expectancy

5 Disability-Free Life Expectancy by Upper Tier Local Authority: England 2012 to 2014, ONS: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/disabilityfreelifeexpectancybyuppertierlocalauthority/england2012to2014

per week, but the average woman in full-time employment earns less than £500 per week before tax and other costs.[6] And the UK now has fewer intact couples lasting to old age, partly due to declining marriage rates, and partly due to the knock-on effects of easier divorce.

In a third of elderly couples over 80, one partner provides upwards of 35 hours of care a week for the other. This is unsustainable. Nor can the elderly rely on their children to care for them as past generations did. Unlike five or six decades ago, the majority of elderly parents do not live with or even near to their children. In fact, fewer than one in seven elderly persons now live with their own children, a trend that looks set to continue as their grandchildren live at home for longer.[7]

The result of these social trends, evidenced in Age UK's recent report, is that the amount of informal care currently provided can no longer keep pace with the growing demand. Although the number of carers is still rising (the latest estimate being over 9 million) the increasing dependency ratio within the population means that there is a growing gap between those who have needs and those who can meet them. A significant number of people who are unable to cope with three or more activities of daily living are receiving no help at all from anyone.

Furthermore, budget pressures are reducing the productivity of the health and care system overall—with people in need of social care occupying hospital beds, too many patients being readmitted to hospitals less than 6 months after an original episode, and increasing numbers of people with care needs presenting themselves in A&E. Perverse incentives do not help: when NHS health care is free, and social care has to be paid for, there are strong incentives on local authorities and on families to keep patients in NHS beds as long as possible—or get them into the NHS Continuing Care system, under which the NHS will pay for their health care, social care and 'hotel' (food, accommodation and sundries) costs, something not matched anywhere else in the system.

5. CONSUMER ATTITUDES

Alongside the rising demand, the realities of supply also add to the challenge. For example, it is difficult to induce people to save—and save over the many years required—for care they have only a one in four chance of needing: and consequently, there is no specially designed savings product for those wishing to put money aside for long term care. Likewise, insurers are unwilling to take on the 'catastrophic' risk that some customers may need care in an institutional setting for many years; so there is no suitable specialist insurance product either.

Somehow, risk must be pooled. There is a growing consensus that this requires some form of government action—say, through making saving or insurance com-

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6 ONS Annual Survey of Hours and Earnings, 2017: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/annualsurveyofhoursandearnings/2017provisionaland2016revisedresults

7 Later Life in the United Kingdom, Age UK: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/later_life_uk_factsheet.pdf

pulsory, or by government sharing the 'long tail' risk, or by making it easier for people to save and insure. There is surely a role too for local government and regulatory initiatives and product redesign (perhaps involving direct financing from the UK life and pension industry) which will cut care providers' costs and improve what is available to those needing to buy care.

Things are not helped by how much of a lottery the system is perceived to be. There is a growing backlash too against the original 'stealth tax' that was created following the 1999 Royal Commission Report on Long Term Care, whereby private payers effectively subsidise local authority service users by paying higher fees than local authority funded residents for the same facilities in the same homes. It was never a viable long-term funding solution, and it raised costs for self-payers, who made up the difference between the local authority fee rates and viable fees for the providers. Indeed, it is now gradually coming to an end as providers separate out their self-pay homes from those providing local authority funded care. The self-pay residents continue to pay higher fees than the market rate would require because of the historic subsidy of local authority users, but they are increasingly accommodated in newly developed homes. Meanwhile, the homes with predominately local authority-funded residents now suffer from a lack of investment. Short term fixes are no longer the answer.

The Dilnot Commission recommendations, currently languishing in the long grass, have shortcomings; they are administratively burdensome and only the care element is covered in the plans. After being reviewed by the Treasury, the proposals would benefit relatively few people to a sufficient extent to make a real difference. The thumbs down from the insurance sector now effectively rules out the Dilnot proposals, in their present form. Yet one clear conclusion from the Dilnot report should not be overlooked: looking ahead to 2030-2035, the next generation of frail elderly will have smaller pensions and less equity in their homes—another reason why the current cross-subsidy approach is not sustainable in the longer term.

6. FURTHER PRESSURES ON LOCAL-GOVERNMENT PROVISION

The April 2016 decision to introduce the National Living Wage, replacing the previous system of benefits and tax credits, has added to the costs of care for all groups. New pension rules and other rules for part-time and full-time workers have had a similar effect.

The fall in sterling since the Brexit vote, and tight immigration controls, are reducing the number of nurses and carers willing to come to the UK to work in health and social care.

Moreover, clarification of the rules whereby carers must now be paid for travel time between appointments—and be paid if on standby while sleeping in the client's home or nearby—has further increased the cost of at-home care.

Remember also that exit barriers are low: caring is a profession that people can easily leave. That is all the more so because a significant proportion of the workforce

are on zero-hours contracts. To retain good people, they must be properly paid. Providers too can very easily close down branches and walk away from contracts.

It seems possible, therefore, that capacity in the domiciliary care sector in the next five years could drop away quite quickly if local authorities can no longer fund the fee scales necessary to match these rising costs.

7. CARE AT HOME

It is questionable how long care at home can continue to be provided as it is today.

The problems have been mounting for some time. Needs testing rules for care at home and in care homes have been tightened considerably since 2005. As a result, hundreds of thousands of care hours per week that would have been delivered in 2005 are no longer delivered today. This tighter rationing, plus people's reluctance to place their parents in a care home, is prompting more families to pay for care in their own homes. The relatively slow growth in the number of self-pay persons placed in care homes confirms this trend.

Care at home often flouts tax and employment legislation, either by ignorance or design. For example, families who are prepared to ignore, or do not know about, the national living wage and working time laws can hire in one-to-one 24-hour care for much less than the cost of a few daily hours of personal care in a residential home that has to pay rates and taxes and follow all the rules.

The standard of live-in care can be poor. Having to live in an elderly person's home 24/7—and respond to their every need, night or day, while being paid far short of the national living wage—is not a job that attracts skilled people. In consequence, many of these carers have little or no training. Almost none, including those funded by local authorities, have any qualification beyond NVQ2 or equivalent. (Only a handful of qualified nurses are involved in the full-time care of the elderly at home: most live-in nursing care is for those involved in road accidents or with serious blood disorders.) Sharing best practice is not the norm: indeed, the majority of live-in carers have no way of checking on the latest best-practice advice. They play no part in government plans for integrated care.

It therefore seems likely that, sooner or later, regulators will crack down on this informal economy, either on the basis of employment law or care standards—and when they do, such care will become unaffordable to thousands of families.

8. THE NEED FOR NEW SOLUTIONS

To sum up, long term care faces the demand side issues of structural changes in society, demographics, medical advances, and the fact that people regard the system as a lottery and are unwilling to insure or save for care. These problems are compounded by the supply side issues of increasing care costs, regulation, general pressures on providers' budgets and the difficulty of retaining quality staff.

This all suggests that some new means of providing care will have to be found. Otherwise, a significant volume of cases of neglect will begin to emerge.

Traditional solutions—such as suggesting that social care should be predominantly provided by the state and funded, like the NHS, out of taxation, no longer look viable. We need to be much more inventive in giving people the incentives to fund themselves, in cutting the costs of care provision, in product redesign, and in making saving and insurance more attractive.

THE SOLUTIONS

9. FUNDING NEW CARE HOME PROVISION

Too much of the social care debate has focused on current systems of provision and how to make these sustainable and affordable to families, local authorities and taxpayers. There has been remarkably little thought about how the provision of more and lower-cost care might be provided—and by whom.

The finance industry, for example, might be a valuable partner in this. Insurers and pension fund managers are always looking for assets to add into their investment mix. Their horizons are very long term, so (in contrast to banks) they are willing to accept lower returns on investments that are secure and durable. Traditionally, that has meant property, but the property market is weakening: retail centres are closing down as shopping moves online, and the demand for office blocks is weakening as more people work at home or in informal settings.

There is, of course, a modest but steady demand for private care homes, and these in turn provide financial institutions with good and long-term property returns. But what is needed is some way of bringing local authority care homes into this sort of arrangement, so that demand is met, care home standards are raised, and pension funds and others get secure long-term returns on investing in them.

The need for new care home developments is clear. Much of the current stock is more than 20-25 years old, and very little is actually up to current standards. Local authorities do not have the money for new build, particularly now that cross-subsidies from private care home groups are drying up, as explained above. And even if a future government simply threw taxpayers' money at the problem, developers would be wary, given past experience.

A better solution would be one that matched the needs of the pension and insurance industries to the unsatisfied demand for new care homes. Insurance and pension fund investors would be happy to commission new care home developments that they could lease long-term (say for 25-28 years) to local authorities. This would also allow local authorities to provide for their caseload with long-term security.

The best arrangement is probably build, own, operate and transfer (BOOT), rather than the current situation. The investors would build the developments and put in the appropriate management (which could be profit-making or non-profit op-

erators) to manage and maintain them (or allow the local authorities to put in operators that met the investors' standards). The local authorities would be buying a whole care package, not just the buildings, over the lifetime of the lease, avoiding the large up-front costs of building new care homes for themselves. Each property would be transferred to the local authority at the end of the lease (at cost), or amortised over its life so the investors would recover their capital over a period of time.

From this arrangement, the local authorities would receive good care home management and high standards. They could phase out their substandard homes in their local market and provide for the unmet demand. Because pension funds and insurers are willing to take lower returns on such long-term investments, the cost to the local authorities would be contained. They could reduce it even further if they provided land from their own holdings for the developments. By using standard design, methods and materials over a large number of care homes, (perhaps fifty or more rather than the two or three that developers build now), construction and operating costs would fall considerably.

10. MAKING PRIVATE PROVISION AFFORDABLE

A new partnership between insurers, individuals and the state could also help people to afford long-term care more easily. Today, many people might be able to save towards their possible costs but find the proposition unattractive. There is only a (roughly) one in four chance of them needing the care, so they are tying up money that might not be needed. Also, they do not know how much to save, since they do not know how long their care needs, if any, might last. And there is less point to saving when those who do not save might get free care anyway.

In principle, insurance might seem to make sense. But there is no market, bec[8]ause the one in four risk is high and because the 'long tail' risk—the risk that the insured person may be in a care home for ten or more years—makes the potential cost uninsurable. That long tail risk is increasing as life expectancy rises, even though most people today enter care homes later and in a more dependent state than they used to.

This is surely an opportunity for a partnership. If people insured themselves for a defined period of care home care (say, six years) and the government promised to meet the costs beyond that, an insurance solution would become feasible and affordable. The fact that more people were insuring would ease pressures on local authority budgets. And insured people could keep more of their own assets to pass on to their families, without the arbitrary spend-down limits imposed by current government policy.

The Dilnot Commission was correct in principle: that, to tackle the funding problem, we need to pool risk and allow the development of insurance options. But their proposals, which involved assessing every person's needs, would be administratively burdensome, open to legal challenges and likely to be seen as unfair in

8 http://webarchive.nationalarchives.gov.uk/20130221130239/http://dilnotcommission.dh.gov.uk/

many cases. Furthermore, their proposals would contribute only to the care element, and not to the additional costs that people face. Our partnership proposal would be much simpler and fairer.

An insurance-based system, with the government as the long stop, would also help clean up the self-pay market. Insurers would charge one premium for a whole service, including care and hotel costs. They would insist on having clear contracts with known future costs—so clients would no longer be presented with unexpected cost increases after they had moved in. Insurers would also put a downward pressure on the level of fees, perhaps insisting that clients choose from a list of approved care home providers, just as healthcare insurers do. All in all, that would reduce costs for the government as and when it did have to step in and would very probably drive up standards as well.

11. ENDING THE HOMECARE RACE TO THE BOTTOM

Social care delivered at home is a prime example of the race to the bottom. Local authorities contract with providers to deliver a certain number of hours (or more often, half-hours and quarter-hours) to particular clients. Travelling between clients is time-consuming, so often the actual time delivered in the person's home is less than that contracted for. Contractors are selected mainly on price, not quality: so even the short time that clients actually get may be time that delivers a very poor-quality service.

What is crucial is not the number of visits that clients receive, but the quality of the care that is delivered. At present, care at home is contracted on the basis of hours or number of inputs, with the focus on price rather than outcomes, and with no encouragement to integrate health and social care. This cannot continue in its present state. Local authorities should look in future to contract with the new providers (who are waiting to come to the UK) who have developed technology platforms and more sophisticated caregiver recruitment, and training plans—the stuff of transformational change. Developing insurance products for long term care will also be a catalyst for network building and technology enablement in this sector. We foresee that commissioners who currently know what they are getting elsewhere in terms of quality standards will want the same level of knowledge for the home care sector.

The entry of insurers into the long-term care sector will be further catalyst for change that would enable all payers to have access to systems that evidence that all parties are receiving value for money and a quality product.

12. THE NEED TO DISRUPT THE MARKET

The debate on social care has centred on how much more of it we can afford, either as individuals or as taxpayers. But with fresh thinking, it is possible to improve the quality of social care without huge costs, to find ways of making it more affordable, to rebalance the market more rationally between care at home or care in a care home, and at the same time to improve the quality of care that is delivered.

If more public funding is needed in order to serve the large unmet and future demand, we need to be prepared to think radically about this too. Over the decades, more and more costs (not just healthcare and social care costs, but pensions and other costs) have been shifted away from elderly people and onto young people. The pensions Triple Lock, free TV licences, lower rates of National Insurance for persons over 60 years of age, Winter Fuel Payments, and Attendance Allowances—all these and more are costs borne by people of working age, who have recently been told that they will have to work even longer before they can enjoy the same benefits themselves. Cynically, one can argue that older people have been promised these benefits because they are more likely to vote. It is still unjust that less well-off younger people should be expected to bear so many of the costs imposed by better-off older people.

It would be fairer, and more efficient, to scrap many of these benefits and end the Triple Lock, so that older but wealthier people make more of a contribution to their generation's care costs. Freezing the Personal Income Tax Allowance for those of pensionable age would ensure that poorer pensioners did not lose out.

A more rational and affordable care system will involve disrupting the market. But the result of that disruption, through methods such as insurance and government cost sharing, or pension-fund financing of care home provision, will be greater supply, greater sustainability and greater fairness. Public sector reforms are part of this: NHS-funded Continuing Care, for example, creates perverse incentives and unfairness, as we have seen. Funding rules—if you go into a care home, your residence is counted under means testing rules if your spouse is no longer with you, while if care is delivered at your residence, it is not—produce other perverse incentives (in this case, making local authorities favour care home provision rather than care in the person's home).

Minor changes to the existing system will do little good and will not help long-term sustainability. What we need are new partnerships in a new market.