Briefing

DEBATE IN THE HOUSE OF COMMONS
8 MARCH 2012
THE FUTURE OF SOCIAL CARE

The King's Fund has a longstanding interest in social care reform. In 2006, we published *Securing Good Care for Older People: Taking a long-term view* following a major review of social care in England led by Sir Derek Wanless. This proposed a 'partnership model' under which responsibility for the costs of care would be shared between the individual and the state. In March 2010, we published *Securing Good Care for More People: Options for reform*, which updated the 2006 report and set out a revised version of the partnership model.

Summary

The need for reform and a sustainable funding settlement for social care has never been more urgent, with local government and NHS finances under significant pressure and demand for services increasing as the population ages. The government must move quickly to bring together its response to the Dilnot report and the Law Commission's review of adult social care law into a single wide-ranging plan for the reform of social care funding and delivery. There should be no further delay in honouring its pledge to publish a White Paper this spring followed by legislation at the earliest opportunity.

- The Dilnot report offers a credible and costed way forward. While further work is required on the detail, the adoption of the recommended capped cost framework offers the prospect of a lasting settlement based on a partnership approach in which costs are shared between the individual and the state in an open and transparent way – a principle we have long argued for.

- The current economic climate is not a reason for delaying acceptance of the framework proposed by Dilnot. However, with the budget deficit in mind, there is potential for a phased introduction of the capped cost model, with the level of cap recalibrated as economic conditions improve.

- There are some 'quick wins' on which work should begin now. These include: raising the upper limit of the means test for residential care; introducing a universal deferred payment scheme; and developing comprehensive information and advice services.

- As the Health Select Committee pointed out recently, progress in integrating health and social care has, so far, been limited. Integrated care should now become a 'must do' priority with services organised around the needs of older people and those with complex needs. Health and wellbeing boards can play an important role in bringing services closer together.

- In the longer term, there is a compelling case for considering how combined public expenditure on the NHS and social care in excess of £121 billion could be consolidated.

Background

The social care system is widely regarded as inadequate, unfair and unsustainable. Under the current means-testing arrangements, anyone with assets of more than £23,250 must pay the full cost of their care. This leaves 1 in 10 people over 65 facing costs of more than £100,000. Eligibility criteria for council-funded services have been tightened so that in most areas only those with very high needs now qualify for help.

Our 2010 report estimated that the cost of the current system, with all its inadequacies, will rise from £6.7 billion in 2011 to £12.1 billion in 2026.[1] The squeeze on local authority budgets over the next four years will see a widening gap between needs and resources. Despite the additional £2 billion announced in the Spending Review and the best intentions of local authorities to protect social care, we estimate that a funding gap of at least £1.2 billion could open up by 2014 unless all councils can achieve unprecedented efficiency savings. The question is therefore not whether we can afford to reform the funding of social care, but whether we can afford not to.

Despite failed attempts at reform, most notably the report of the Royal Commission established by the Blair government in 1999, and the previous government's proposals for a National Care Service, which were aborted after the general election, there has been progress recently.

- The Law Commission published recommendations for modernising the legal framework for social care in May 2011.
- The Commission on Funding of Care and Support published its report on 4 July 2011.
- The Department of Health subsequently launched an engagement exercise on the future of care and support that concluded in December 2011.
- The Health Select Committee held an inquiry into social care that reported on 1 February 2012.

These developments have helped facilitate a strong consensus about the key elements of reform that we hope will act as a catalyst for agreement in the cross-party talks currently taking place. We now await a White Paper on social care reform and a 'progress report' on funding in the spring.

The Dilnot report

The Dilnot report provides a framework for a long-term settlement for funding social care. The funding model proposed aims to eliminate the catastrophic care costs faced by some people by capping the maximum amount individuals contribute over their lifetime, beyond which the state will meet all future cost. By limiting people's liability in this way, the Commission expects a market to develop for financial products so that people can insure themselves against the cost of their contribution. The key recommendations are:

- the lifetime contribution any individual makes towards the costs of their care, excluding general living costs, should be capped at between £25,000 and £50,000, with the Commission recommending the cap should be set at £35,000
- the asset threshold above which people in residential care are liable for the full cost of their care should be increased from the current level of £23,250 to £100,000
- people in residential care should make a standard contribution to cover their general living costs of between £7,000 and £10,000 a year
- eligibility criteria for services should be set nationally as part of a clear national offer, and needs assessments should be 'portable' between local authorities
- a new information and advice strategy should be developed, a national awareness campaign should be launched to encourage people to plan ahead and the deferred payment scheme should be improved

- social care and welfare benefits should be better aligned, Attendance Allowance re-branded and carers' assessments improved
- integration between social care and other services, especially the NHS, should be improved, and a stronger emphasis placed on prevention.

If the Commission's recommendations are implemented in full, it forecasts that no one would have to spend more than 30 per cent of their assets to fund their care. It estimates that its recommended changes to the funding system would require £1.7 billion in additional public expenditure (0.14 per cent of gross domestic product (GDP)) if the cap on individual contributions is set at £35,000, rising to £3.6 billion (0.22 per cent of GDP) by 2025/6.

Unmet need

The estimated costs associated with the capped cost model recommended by the Dilnot report relate to additional expenditure from implementing the new proposals only. The overall level of resources required by the current system was outside the Commission's terms of reference, but the report makes clear that in addition to funding for the new proposals, 'additional public funding for the means-tested system' will also be needed. Unless this is addressed, many of the well-chronicled problems with the current system will continue, including escalating levels of unmet need – currently affecting 800,000 people – and underinvestment in preventive support.

Implementing funding reform

The Dilnot Commission's proposals to cap individual liability for the costs of care and to raise the upper threshold for the means test would represent a substantial improvement on the current system and ensure that people in every income group are better off. This would avoid placing disproportionate costs on the taxpayer, compared to the costs of providing free personal care, while protecting people from the worst excesses of the current system and the cliff-edge of the present means-testing arrangements.

Questions of affordability go beyond the current economic situation and the budget deficit is not a reason for delaying acceptance of the framework proposed by Dilnot. The additional public spending needed to fund the proposals is less than 0.25 per cent of GDP. Including the cost of meeting unmet need would bring this up to around 0.5 per cent of GDP. The government's decision to find an additional £1 billion for weekly council refuse collections and to freeze council tax is a reminder that the primary issue is one of relative political priorities rather than absolute affordability. As the Secretary of State for Health stated in a speech in 2010: *'Despite the financial crisis – perhaps because of it – we can't let long-term care be kicked into the long grass.'*

With the forthcoming Budget in mind, there is also a broader economic case for investment in social care. Public spending in this area currently represents 1.2 per cent of GDP, the majority of which is accounted for by the wages of the 1.5 million people who work in the sector that is not characterised by high levels of pay. Any additional investment therefore could create a significant multiplier effect and would support a strategy for economic growth. Further economic benefits could be expected from better social care support for carers and for people with disabilities who would be more likely to retain employment.

Nevertheless, we recognise the difficulty of identifying new resources in the current economic climate – this supports the recommendation of our 2010 review for a staged, long-term approach to reform. The government should endorse the capped cost framework set out in the Dilnot report without delay. However, with the economic climate in mind, there is potential for a phased introduction of the capped cost model, with the level of the cap recalibrated as economic conditions improve. This gives the government some real choices about timing and the level of the cap, which seems unlikely to be less

than £50,000 in the short term. Coupled with a higher cap of £10,000 for living costs, this could see the initial cost of implementing the recommendations fall to £800 million.

While the detail of this is worked through, there are some immediate steps that are uncontroversial and would not require substantial additional resources. These include:

- raising the upper threshold of the means test for residential care to £100,000 – this would particularly benefit those on modest incomes who are heavily penalised under the current system and would involve a relatively modest cost of £100 million
- introducing a universal deferred payment scheme would help detoxify the issue of people selling their homes to pay for care
- developing comprehensive information and advice services to help all service-users, their families and carers to navigate the care and support system.

The extent to which the financial services industry, particularly insurers, will respond depends on a stable policy environment, which in turn requires a broad consensus across the political parties that will endure beyond a single parliament and across several generations. Financial products linked to pensions or housing assets will require effective regulation and high-quality advice and information to gain public confidence.

Health and social care integration

Integrated care has been a recurrent goal of public policy under successive governments for more than 40 years. Despite some notable successes, progress has been limited, with less than 5 per cent of NHS and social care budgets subject to joint arrangements and wide variations across different parts of the country in the quality and achievements of joint working. The Dilnot report called for improved integration of health and social care, the NHS Future Forum argued that *'we need to move beyond arguing for integration... to making it happen'*, while the Health Select Committee's recent report on social care *'found precious little evidence of the urgency which it believes this issue demands'*.

There has been some progress under the current government, with the welcome transfer of £648 million from the NHS budget to social care rising to a total of £1 billion by 2015, with a further £150m allocated in January 2012. We welcome the amendment made to the Health and Social Care Bill in the House of Lords which will allow these arrangements to continue in future by making it clear that the Secretary of State can direct the NHS Commissioning Board to transfer NHS funding to social care and other community services.

Clinical commissioning groups and health and wellbeing boards could provide a platform for promoting integrated care. Joint strategic needs assessments also offer a mechanism by which the commissioning and planning of services can be better co-ordinated across health and local government boundaries. However, legislation is only the starting point. Experience shows that the key to delivering integration is stable leadership and an evolving vision and trust between local partners.

A more ambitious approach is required. Earlier this year, our joint report with the Nuffield Trust called for health and social care services to be organised around the needs of older people and those with complex needs.[2] It set out how this could be achieved by setting an ambitious new goal to improve the experience of patients with complex needs, backed by enhanced patient guarantees including an entitlement to an agreed care plan and a named case manager responsible for co-ordinating care. The report was strongly endorsed by the Health Select Committee in its report on social care.

In the long term, efforts should be focused on aligning the total spend across the NHS and social care – now in excess of £121 billion – around the needs of patients and service users through mechanisms such as joint agreements, pooled budgets and place-based

approaches. In the longer term, there is a case for moving towards a single, strategic assessment of the funding needs of the NHS and social care.

Addressing regulatory failure and making the market work

The demise of Southern Cross prompted widespread public concern about potential failure in the care home market. However, while 80 per cent of care is provided by independent providers, failures have been relatively unusual – less than 1 per cent of care homes closed in 2009/10.

The key lesson that emerges from Southern Cross is the need to be much clearer about the respective roles of providers, commissioners, regulators and central government in sustaining a vibrant market that is responsive to needs but protects continuity of care. This involves the following four functions.

- Sharpening existing regulatory arrangements to minimise the risk to individual care arrangements for vulnerable people as a result of financial or business failure, for example, by building on the Care Quality Commission's existing powers under regulation 13 in relation to the financial viability of providers.

- Market oversight – making better use of intelligence and data about trends and developments at local, regional and national levels that would help identify emerging problems with individual providers.

- Market shaping – where local authorities and other commissioners seek to secure the right type and balance of provision to meet the identified needs of their population; successful market shaping will almost always involve provider exit and entry.

- Information and advice, particularly in relation to financial advice for individuals and a stronger approach to reassuring residents and relatives when homes are experiencing difficulties.

There are a number of options the government could consider in clarifying and strengthening current arrangements to protect individuals from provider failure.

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[1] *Securing Good Care for More People: Options for reform,* The King's Fund, 2010
[2] *Integrated Care for Patients and Populations: Improving outcomes by working together,* A report to the Department of Health and the NHS Future Forum *,* The King's Fund and the Nuffield Trust, January 2012