



Futures debate

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PAPER 1

Funding tomorrow today

Social care for older people and vulnerable adults

Key points

- The current social care system is unable to deliver targeted social care to all those who could benefit from it, let alone universal provision.
- Social care users are currently a small subset of the population who have little voice and not much choice.
- If services need to be individually tailored, they will have to be much more directly accountable to users.
- The blurred and hard-to-define line between nursing and social care for people with long-term needs has not been addressed adequately.
- Elsewhere in Europe, the benefits and income support system are better connected.

An effective social care system is an essential part of any civilised society and the NHS cannot fulfil its function effectively if it is not working well. A number of publications and statements over the last couple of years have led to the disturbing impression that the social care system is fundamentally in trouble.

Background

As the population grows older, the debate about how the present system can be funded to make it sustainable in the future is gathering pace. The current Government has characterised the delivery of adult social care in the future as 'progressive universalism' with a core universal offer and local authorities acting as both 'care navigator' and procurer of services, with costs shared between the individual and the state. However, there is an underlying question that needs addressing – how do we make social care for individuals affordable and sustainable in the long term?

Current systems, already under pressure, will have difficulty

sustaining care for increasingly aged and infirmed service users. Provision is limited by eligibility (with most authorities only providing services to those with substantial or critical needs) and ability to pay (with support for residential care limited to those with assets of less than £21,500).

The current system is not delivering targeted services to all who could benefit from them, let alone services based on universalism. Tweaking around the edges will not produce a solution that is future-proof. The solution to the social care funding crisis lies in a hybrid model that combines a minimum level of government-funded care with individual top-ups and insurance.

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The current system and why it's not working

Social care is not understood

The first indication that there is a significant problem is that social care is not widely understood. *Our health, our care, our say* describes social care as “the wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships”. This is too general to be useful, and as the Platt report acknowledges it is not even a widely held definition.¹

Furthermore, there is a crucial omission. The term ‘vulnerable’ does not just refer to the needs of the individual for support; it also has a financial dimension. We know that the public are prepared to make difficult choices around funding social care. However, it is not widely understood that material help is only available to those who have very few assets and very little income. People who have saved, acquired assets or made provision for their old age unsurprisingly resent a settlement that appears to penalise financial prudence. And all this goes against the principles that Wanless, Joseph Rowntree and other authorities suggest should underpin the system (see page 4)².

Paul Coen from the Local Government Association provides a much better definition of both social care and the problem: “The goal of social care is to allow people to live independent lives. If a service creates dependency, then it has failed.” This

“People who have saved, acquired assets or made provision for their old age unsurprisingly resent a settlement that appears to penalise financial prudence”

is much better, but he adds: “Too frequently the traditional model – unlike direct payments – has tended to do this.”

A quadruple lottery

In social care, the postcode lottery is at least as pronounced as in healthcare. There are variations in the application of the needs threshold within and between areas: having won through this double lottery financial eligibility criteria are applied in different ways, and the level of charges varies significantly between areas. Those who are not eligible may often get very little help finding services to meet their needs.

Misaligned accountabilities

Improving quality, extending coverage and the personalisation of social care services will be interesting to a relatively small group of current and potential users, but council tax payers with no personal investment in these issues may take a different view, particularly if the result is a large increase in their bills for a service they do not themselves receive and from which they may never benefit. If social care services are to be individually tailored, they will have to be much more directly accountable

Key demographics

- The numbers of older people will rise by 400,000 over the next three years, particularly those over the age of 85.
- By 2051, the population aged over 85 years will have increased by 169 per cent from current figures.
- 2007 is the first year when people over 65 years of age outnumber those aged under 18 in the UK.
- 25 per cent of the 85+ age group have some degree of mental impairment. In 30 years' time there will be one million people with dementia, with more than 480,000 carers, of whom a substantial number will themselves be older people.
- 1.2 million people use council-facilitated social care services; most are older than 65.

to users. In the NHS, because funding comes from general taxation there is better alignment between the people who pay and the people who use the services.

In kind but not cash

The objectives of social care include supporting independent living, but it does so by providing services almost entirely in kind. For all the brave talk

¹ D. Platt, 2007: *The status of social care – a review* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074217

² D. Wanless, 2006: *Securing good care for older people: taking a long-term view*. King's Fund

of direct payments and individual budgets, these seem painfully slow to get off the ground.

Lack of integration

In many other European countries the benefits and income support systems are more connected. Glasby argues that the UK's position is a direct consequence of removing the stigma of the 1834 Poor Law from the social care system.³ One consequence of this has been that local authorities have tended to assess benefits as part of income and taken this as a contribution to the costs of care. However, allowances were intended for the broader costs associated with having a disability, not just the costs of direct care. A second consequence is considerable complexity, different eligibility

“The accountability in social care is to the people who fund it, not to those who use it”

criteria, a need for multiple assessments and a system that may not be targeting resources optimally.

Pooled budgets and improved partnership working have dealt with some of the worst problems between health and social care, but some fundamental issues remain. Firstly, it is genuinely difficult to draw a line between health and social care, particularly in long-term care for older people. A number of countries have stopped trying and have introduced a single funding stream. Secondly, the methods of allocating resources to

different funding streams do not take account of each other. This has led to unproductive allegations of local authority cost-shifting by the NHS and bids for NHS money by social care.

Intergenerational problem shifting

Participants in the debate seem to take it as read that the growing cost of future care will be paid for by future taxpayers. We have now reached a point, which surely was predictable, where growing demand and a shrinking workforce mean that such intergenerational transfers of obligations will be much more difficult.

Missed opportunities in prevention

In the NHS, we are all too familiar with a system that concentrates on patching up problems rather than dealing with the fundamentals and prevention. We are good at rapid but expensive short-term answers to problems rather than taking time to develop more appropriate solutions. However, it appears that this is also a feature of parts of social care. There is limited hard evidence that a preventive, rather than a rescue-based, approach can make a major difference. However, it appears that the focus of social care on the most significant areas of need is forcing people with lesser needs into residential care unnecessarily. The Commission for Social Care Inspection reports too many instances where, because of the need to make rapid decisions or the lack of availability of a 24-hour rapid response, people have been forced into choosing residential solutions, where home-based alternatives might have been better.

The current situation

- More than 90 per cent of adults expect subsidised care from councils in their old age, but 70 per cent of councils now only provide care to people with the top two levels of need – substantial or critical. Four councils are supporting only people with critical needs. On current projections, all councils will be providing substantial or critical care only by 2009.
- £46 billion is spent by councils on all local services. Councils raise £23 billion from council tax, £19 billion from non-domestic rates and get £4 billion from general taxation. The Wanless Report² (2006) estimated that local authorities spent £8 billion on social care in 2004/05, £1.6 billion of which was recouped from means-tested charges.
- £3.7 billion was paid in non-means tested benefits to individuals to help with the costs of care in the same period, and private spending on care homes is estimated at £3.5 billion per year.
- Around half the expenditure on personal social care for older people comes from private contributions or charges and top-ups. This is estimated to total nearly £5.9 billion.

³ Jon Glasby, 2007: *Understanding health and social care*. Policy Press

What is the way forward?

It is clear that there are no easy short-term solutions beyond a major increase in funding and addressing some of the most significant problems of lotteries and gaps.

It is also clear that there needs to be a very clear statement of what the public can expect, their responsibility for making a financial contribution and what the consequences will be if they do not make provision for this.

The NHS Confederation has been gathering ideas from a number of sources and the following policy prescription is intended to start a debate.

A standard minimum entitlement

This would remove many of the current problems of variations in entitlement. Wanless says that this could be set nationally or locally, but the logic of his argument seems to strongly favour a national benefits package – which is the case in many other countries. This type of minimum benefits statement is difficult to produce in healthcare, but does not seem to have the same hazards in social care.

Cost-sharing between the state and individuals

Two series of deliberative events – Your Health, Your Care, Your Say, and Caring Choices – highlighted that the public are prepared to make difficult choices around the funding of services and of care, including considering co-payment models for social care. Caring Choices found that almost 75 per cent of participants believed that the costs of long-term care should be shared between the Government and the individual. Most people were in favour of the state supporting schemes such as equity release that help to unlock private resources or enable private contributions to the cost of care.

Principles for social care reform

- Grounded on principles of social justice
- Based on need and ability to pay in a progressive way
- Avoids penalising people who make their own financial provision
- Shared responsibility between individuals, the family and the state
- Treats all citizens equally, regardless of the nature of the needs of care
- Accepted as fair (both between individuals and across generations)
- Encourages informal caring in a fair and economic way
- Transparent, sustainable and affordable
- Encourages an efficient supply of services and preventive measures
- Recognises the diversity of needs and allows recipients to retain their dignity.

Source: Wanless Report, Joseph Rowntree Foundation, Melanie Henwood

Bringing together different funding streams

Bringing social care, benefits and elements of health spending into a unified individual budget would enable individuals to obtain services in kind and make direct payments.

Adopting the partnership model

The partnership model proposed by Wanless has the potential to achieve many of the goals of reform, could protect assets and removes the disincentive to save. But it does

not deal with the problem that our children may not be able (or willing) to pay the bill for our future care. We need to start saving now to be able to pay the additional amounts above the minimum entitlement we will need.

Topping up partnership with social insurance

The need to make provision for the future and a general policy imperative to improve personal ownership in the system suggests that the Wanless partnership model may need some form of social insurance contribution either linked to pensions or as a separate contribution. This may need to be compulsory – albeit with an opt-out for the most wealthy and tax-funded top-ups for the poorest.

Insurance plans providing individual choice

These would promote personal and family responsibility and ensure that up-front decisions about funding expectations could be made proactively. They would also enable diversity of need to be addressed and the extent of co-payment to be set in advance.

Rethinking social care commissioning

Individual budgets, and direct payments combined with a principle of entitlement to a minimum package, would change the role of commissioners very significantly.

Mike Reid from Care and Health has a strong view on the future of commissioning in social care. He believes that personalisation captures the *zeitgeist* of consumerism and choice and changes the role of the commissioner so substantially that today's skill sets and groupings would have to change. The current role of taking identified needs and going

into the market to find solutions for them on behalf of service users would become redundant. And it has the disadvantage of creating an additional task in the route to people getting services. This middleman role may add little value other than allowing the Government to exert its buying power.

Reid believes the new commissioning role would be that of market shaping, more akin in nature to that of a regulator or central bank than a sophisticated purchaser. This means that the new role would have to go beyond current aspirations. The most forward-looking commissioners would need to create an environment with open information and the freedom of market operators to act. Commissioners would need to have an educational, brokering role concerned with local workforce and entrepreneurial flexibility so that the

commissioning process would act far more as a business stimulator. The key role in commissioning in future would be played by the user and the professional, or carer responsible for coordinating the resources.

If commissioning is changing in this way, there is a question about who is best placed to lead it in future. Local government could still have a key role but the providers of insurance and partnership funding would also have a key relationship to the users of social care and less institutional baggage.

Another group might also be interested in taking on the challenge, particularly if the key role is putting together integrated health, care and benefits packages. Mo Girach, chief executive of the level 3 St Alban's and Harpenden practice-based commissioning group, argues that proper planning,

coordination and performance management has the potential to revolutionise care by bringing health and social care commissioning together. There are significant opportunities to improve the coordination and management of care for people, particularly those who are heavy users of both health and social care. He argues that practice-based commissioning with a single needs-based allocation, combined with the mechanisms described above, could provide a powerful engine for improved health and social care commissioning. Responsibility would be delegated from local government and primary care trusts (PCTs) and individuals would have a key say in how the package of care is designed. And because practices are close to the user they would be able to bring all the resources together to create a truly integrated health and social care model.

How other systems have dealt with the issues

Germany

In 1995, Germany added long-term care to its social insurance system, funded by new payroll charges on employees and employers. A single needs assessment unlocks payment based on dependency and what form of care is used. Most popular is the family payment which has lower value in kind/cash allowances than opting for a package including professional care. Some 80 per cent of care recipients choose to get benefits as a cash allowance rather than receiving benefits in kind.

Japan

Japan altered its system in 2000. A tax-funded entitlement system, with compulsory social insurance premiums for those over 40 years

of age, pays a flat rate of 90 per cent for all care homes and home care. The remainder comes from a private co-payment. Japan does not offer support for family care as it feels that this places an excessive burden on families in general and women in particular. Some readjustments in 2005 added charges for personal care and domestic services in residential homes as a way of encouraging people to use home and community services. This has been coupled with an increase in the numbers of preventive services offered to those at risk of dependency on care. Care coordination is provided through a community support centre which administers assessment and care planning. A mix of for- and not-for-profit providers are then commissioned to provide services.

The Netherlands

The Netherlands was the first country to introduce social insurance for long-term care in 1968 and this has remained separate to its healthcare system to this day. It covers institutional and home-based care, personal and domestic help. The insurance contribution constitutes 12 per cent of salary, all of which is contributed by the employee. There are also income-dependent co-payments. Despite being a social insurance model, both central and local government exert high levels of control on the system. They grant five-year contracts to sickness funds and control of entry and exit to the provider market.

Continuing nursing care

The blurred and difficult-to-define line between nursing and social care for people with long-term needs has not been addressed adequately. One of the contributors to the ideas behind this paper suggested a further step that is much more radical: to apply the same logic set out here to continuing nursing care. This would involve a guarantee of a specified level of financial support to be topped up in the same way as social care through equity release or an insurance policy. Versions of this are found elsewhere in Europe, but they have different approaches to funding and are less concerned about the division between free healthcare and paid for social care. Is this one step too far?

Conclusion

The UK's social care system is in difficulty and an honest debate about a social care model for the future, particularly its funding and commissioning, has begun. It is very welcome that the Government and opposition parties are committed to a wide-ranging and detailed debate. It is clear that the solutions need to be radical and the question is how to take the process beyond the usual participants in the debate to become sufficiently forward looking. A similar approach to the cross-party

approach to a radical solution in pensions is required.

The way forward suggested in this paper has a number of significant advantages:

- Removing means testing and introducing a partnership model based on social insurance removes the disincentive to save while helping the poorest.
- Putting a mechanism in place now would deal with future funding problems, rather than waiting for another green paper in 15 years' time.
- The scope for arguments, cost and blame shifting between sectors would be reduced.
- The system would become less complex, more transparent and easier to navigate.
- The new system would empower the users of services much more effectively.
- Insurers would have an interest in investing in prevention and interventions that stop rapid descent into using high-cost services.
- Moving the benefits and care systems closer together would remove some of the perverse consequences of the current system

and revolutionise the financial and other support available to users and unpaid carers.

Sorting out the funding of social care is vitally important. But a similar radical reshaping on the provider side may also be required to meet the challenges of a much more dynamic funding system as well as the shrinking workforce and growing demand we face.

Join the debate

- What are your views on the ideas covered in this paper?
- What other solutions should be considered in the forthcoming social care funding green paper?
- Should continuing nursing care be part of this debate?
- How radical can we be?

Have your say now in our social care funding forum at www.debatepapers.org.uk

The debates will feed into the NHS Confederation annual conference and exhibition, Delivering the Future Today, in Manchester from 18 to 20 June 2008.

The author, Nigel Edwards, is director of policy at the NHS Confederation.

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The NHS Confederation
29 Bressenden Place London SW1E 5DD
Tel 020 7074 3200 Fax 0870 487 1555
Email enquiries@nhsconfed.org
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