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The future of social care in the UK

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Abstract
Labour's white paper 'Building the National Care Service' published shortly before the 2010 general election announced plans for major reform of the funding and future of social care in England. In so doing it reopened longstanding debates about the principles on which such care should be based, taking into account acknowledged inequities in the current system. The new government coalition of Conservatives and Liberal Democrats raises questions as to the direction of travel for social care.

This paper charts developments since the inception of the welfare state to the present time. It shows how, regardless of political party, each successive administration has played its role in the move away from care delivered on a universal collective responsibility to increasing individual responsibility where risk and costs of care are held at the individual level. The current promotion of personal budgets and direct payments is described along with the risks for providers and users. Finally, the future of social care is considered in light of the plans of the new Conservative/Liberal Democrat coalition. We conclude that social care will continue to be a personal and not a collective responsibility, paid for by private contributions and where private insurers play a role, despite evidence to the contrary. All governments relegate social care to low priority status and this is likely to continue.

Keywords: Social care, funding, long-term care

Plans for reform: 2009-March 2010

In 1997, New Labour inaugurated its first term of office with a Royal Commission on Long Term Care (1999) but, having comprehensively rejected the Commission's core recommendation that care should be a universal right funded from taxation, the policy was resurrected ten years later in the government's dying months before the May 2010 election. Labour articulated a wish to reform the funding and future of social care and argued for a new National Care Service (NCS) to rival that of the NHS for England. In so doing, it reopened the debate about the principles on which social care is based and acknowledged inequities in the current system. A white paper *Building the National Care Service* published shortly before the general election described a new social care service to be implemented in three stages (HM Government, 2010).

The inequities and inadequacy of current policy on social care is well argued in the comprehensive and critical report of the House of Commons Health Committee (House of Commons, 2010). The government held a public consultation (HM Government, 2009) on three funding options:

1. Partnership - a proportion of basic care and support costs paid by the state according to means, based on a model by Wanless (2006) but without his proposal that the state would match individuals' contributions on top of a basic state contribution;
2. Insurance - state support as in the previous option but with additional costs covered through either a private or state run insurance scheme;

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3. Comprehensive - everyone over retirement age able to do so to pay into a state insurance scheme, then those qualifying would get all basic care free.

Two further options were ruled out; no state support or a fully tax-funded system as for healthcare, discounted on the basis that it placed too heavy a burden on the working population.

All funding options apply only to 'care and support' and not to accommodation (hotel) costs such as food and lodging. 'Care and support' refers to; *personal care* to assist with the tasks for daily living; *home care* which includes care such as help with cleaning and shopping; *community care* such as meals on wheels and day centres; and *residential care.* It is estimated that, currently, around 20% of people will need care costing more than £50,000 and, for over 5%, this will cost more than £100,000. Long-term care can cost people around £12,000 per year (HM Government, 2010). The white paper announced that the result of the public consultation was that the Comprehensive option was most favoured and that, "it is time to build a comprehensive National Care Service that is universal and free when people need it" (p.12).

However, the means of funding such a service was left to a new Commission, yet to be appointed, whose recommendations if approved would not be implemented until 2015. It remains to be seen if, when and how the Conservative and Liberal Democrat coalition will take forward these policies. Long-term care may prove to be the dividing line in the coalition. The Conservative manifesto commits to increased personalisation, privatisation of responsibility through even greater use of direct payments and individual budgets. For older people they propose a voluntary 'home protection scheme' which would involve pensioners paying a one-off £8,000 fee into a privately run insurance scheme that would ensure that all their residential care costs are covered, the evidence for which is far from sound. Indeed the US experience shows this is an unworkable policy. The Liberal Democrats do not support this policy, not least because two thirds of pensioners' chief assets are their homes, i.e. they are asset rich but income poor.

Developments in social care from its inception until the current day

The debate on funding takes place at a time of major economic downturn and recession and after a long period of incremental privatisation of public services. We describe here the key developments that have impacted on social care since its inception so as to better understand the current situation. A chronology of significant policy developments is outlined in the Appendix.

Long-term care

Whilst health care is organised and funded on collective principles, older people carry the main responsibility for funding their care themselves until too poor to do so. Long-term care has been virtually eliminated from NHS and local authority provision and is now largely under the control of the mainly for-profit independent sector. In England, 4,000 private care agencies provide home care, with 14,000 private care homes, whilst third sector organisations have over 500 home care agencies and run more than 3,000 homes (HM Government, 2010). Many people depend on unpaid help. There were 5.2 million carers in England and Wales according to the 2001 national census, with over a million providing more than 50 hours care a week of whom over 225,000 were not in good health themselves (ONS, 2001). Most carers are of working age, with women more likely to work part-time.

The divide between health and social care

Many of the current inequities in social care date back to the inception of the NHS. The immediate post-war period promised better and fairer treatment for sick, older people, with the reviled Poor Laws abolished. Two welfare reform acts passed, the 1946 National Health Service Act and the 1948 National Assistance Act, promised that the state would provide universal health care for all as a right, irrespective of age or ability to pay. However, these acts established two parallel systems. Whilst the NHS provided universal health care free at the point of delivery, under the National Assistance Act local authorities would provide a subsidiary system for those in need of other 'care and attention', primarily frail older people. Unlike healthcare, this was means-tested and subject to statutory charges, providing a safety net rather than a universal service on the assumption that care would be mainly provided by family and voluntary carers.

This distinction, introduced by Bevan, created a fault line between the 'sick' and those needing 'care and attention'; the latter of which has been expanded to include a range of chronic illnesses and diseases. This was never the intention; it had not been anticipated that the National Assistance Act would be applied to those with considerable health care needs. The post-war Labour government had envisaged the construction of high quality residential care homes relying, in the meantime, on voluntary 'third' sector organisations such as the Salvation Army, Darby and Joan homes, church organisations and others. But, despite its major role, this third sector was neither large nor co-ordinated enough to assume responsibility for domiciliary services, so legislation in the late 1960s enabled local authorities to provide such services, with the state becoming the main provider until the end of the 1990s. Local authorities also assumed responsibility for older people who became ill, so came to look after more heavily dependent older people in care homes within a means-tested system where charges could be levied.

Private sector involvement in care for older people

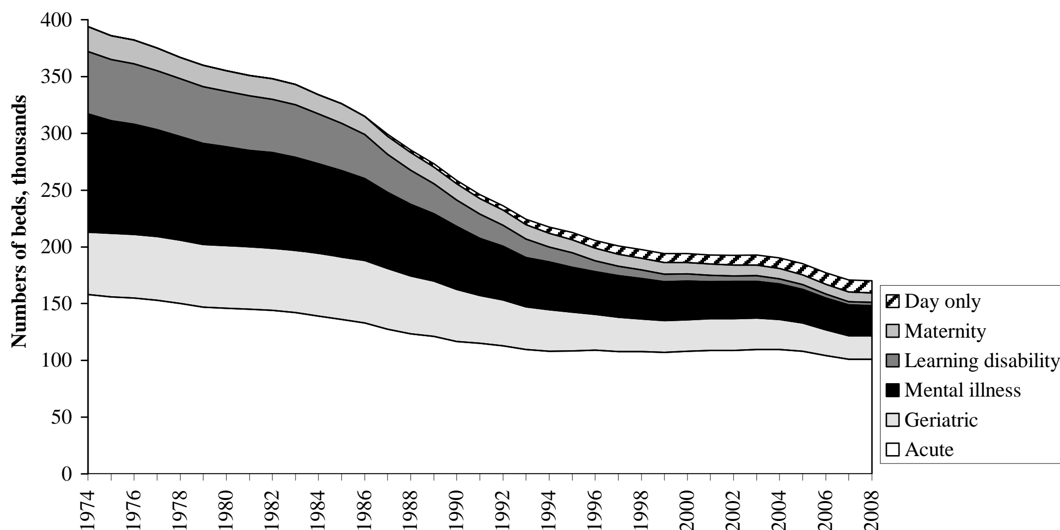
To the incoming 1979 Conservative administration, social services provided good potential for increased private sector involvement and promotion of a market. This sat with the belief that families and charities should bear the primary responsibility for care. As income from cash-strapped local authorities reduced, voluntary organisations responded by lobbying government and so local Department of Social Security offices (DSS) started to pay supplementary benefits to meet care home fees, a policy that was formalised in 1983 with the result that the care home sector became largely subsidised by DSS benefits. As the DSS would only fund people in voluntary or private homes, councils cut back their own provision. Unlike local authority homes there was no assessment of need for services and, as it cost councils nothing to place people in a home, many ended up in institutions rather than receiving services to remain independent. As intended, new corporate providers were attracted to the market with the result that policy had the effect of replacing state with private sector provision almost overnight. In effect, the government had established a voucher system for the public funding of private and voluntary care homes, with fees paid from the social security budget to the benefit of private providers.

Following concerns over the rising social security bill, the government under Margaret Thatcher asked Sir Roy Griffiths to review the funding of community care. Subsequently, the 1988 Griffiths Report and the 1990 NHS and Community Care Act accelerated developments, recommending that local authorities should move away from directly providing care to become purchasers within a mixed economy.

After 1993, local authorities had to fund all community care from the Personal Services allocation in the block grant they received from central government, but the impact was softened by a Special Transition Grant (STG), of which 85% had to be spent in the independent sector, thereby forcing councils to contract out. The Community Care Act also required them to take over the funding of nursing home care, so contracts with the independent sector became the main way of delivering services. Councils received a further incentive to use the private sector by allowing them to recoup part of their residents' Income Support benefit (residential allowance), but only for those in private homes. Not surprisingly, many councils transferred or sold their own care homes in a major, under-reported sell-off to the independent and voluntary sector often at knock-down prices, i.e. some residential homes in Scotland were disposed of for a pound (Accounts Commission, 2000). Not only had the state guaranteed private providers an income stream, it had also transferred to them substantial assets, that had been publicly paid for, at little or no cost.

The general government interpretation of care *by* the community as opposed to care *in* the community placed an increased financial burden on individuals themselves as cash-strapped local authorities became obliged to ration and charge for care accompanied by large cuts in NHS beds for older people. Figure 1 shows how, since 1979, around 200,000 NHS beds in England have been closed, despite the findings of the 2000 National Beds Inquiry (DH, 2000a) that bed closures had gone too far and the subsequent promise of increasing the number of NHS beds in the NHS Plan (DH, 2000b). Although many geriatric facilities badly needed replacing, eliminating NHS provision transferred costs to individuals on a huge scale. Though impossible to quantify, current levels of ill-health amongst older people in nursing homes suggest that a significant proportion would have received free NHS care in the past.

Figure 1 Average number of NHS beds available daily, England, 1974-2008



Sources: Department of Health form KH03, Hospital Activity Statistics for figures from 1987-88
Acknowledgement to Alison Macfarlane for earlier statistics derived from DHSS and DH statistical bulletins

In 1994, the Department of Health introduced eligibly criteria for free NHS care, ruling that this was only a right for those with complex or multiple healthcare needs requiring continuing and specialist medical or nursing supervision. Local authorities were required to assess needs and financial eligibility for long-term care, with most providing for only the most dependent. Meanwhile, financial pressures encouraged councils to apply user charges for all services including domiciliary care; from the early 1990s, central government made the assumption that 9% of domiciliary care costs would be recovered through charges. Accordingly, by 2000, 94% did so (Audit Commission, 2000). As there is no national means-test, local authorities can set their own policies giving rise to huge variations in charges for people with similar needs. Currently, councils recoup 11.8% on average of homecare costs through charges (House of Commons, 2010). Financial pressures also encouraged councils to try harder to coerce older people to sell their homes to pay for residential care.

Entrance of the Labour administration - the Commission on Long Term Care

When Labour came to power in 1997 there was intense pressure to redress inequities in long-term care. The new government declared this a priority with the Prime Minister stating that he did not want children brought up in a country where the only way older people could get long-term care was by selling their home (Labour Party Annual Conference, 1997). Subsequently in 1999 a Royal Commission was established to "examine the short and longer term options for a sustainable system of funding long-term care for elderly people and to recommend how … the cost of such care should be apportioned between public funds and individuals" (Royal Commission on Long Term Care, 1999). The main recommendation of the subsequent report was that long-term care costs should be divided between living costs, housing costs and personal care, the latter of which should be free. However, for two dissenters of the 12 member commission, Joel Joffe and David Lipsey, old age was a time of '*rights and responsibilities'* and they recommended that personal care should continue to be means-tested. The government's response published in an appendix to the *NHS Plan* (DH, 2000b) sided with this minority view, and declined to make an official commitment to free, comprehensive long-term care as recommended by the Commission.

There were practical problems in distinguishing between nursing and personal care. Criteria varied between local authorities with some care home residents paying for services they were legally entitled to. To address this, free nursing care was introduced in 2001 for residents who paid their own fees categorised according to their level of dependency. However, payments did not necessarily meet the actual cost, leaving a shortfall for residents to pick up. Even those qualifying may have to 'top-up' the basic package, sharing costs with the local authority through a legal contract. Also, as payments are made directly to care home owners, the government is not authorised to intervene in this private relationship so cannot prevent increases in fees, eliminating the benefits of the system. Because of this, the Scottish Parliament implemented the Royal Commission's recommendation in 2002 so that Scottish residents, aged over 65 and in need, receive free personal care.

Intermediate care

Though Labour phased out the residential allowance and the STG requirement, the culture of contracting out was well-established and local authority provision continued to decline as central government cut funds from which councils could borrow to invest in their own homes. Further, under the 1999 *Best Value* policy, councils had to demonstrate that their own services were

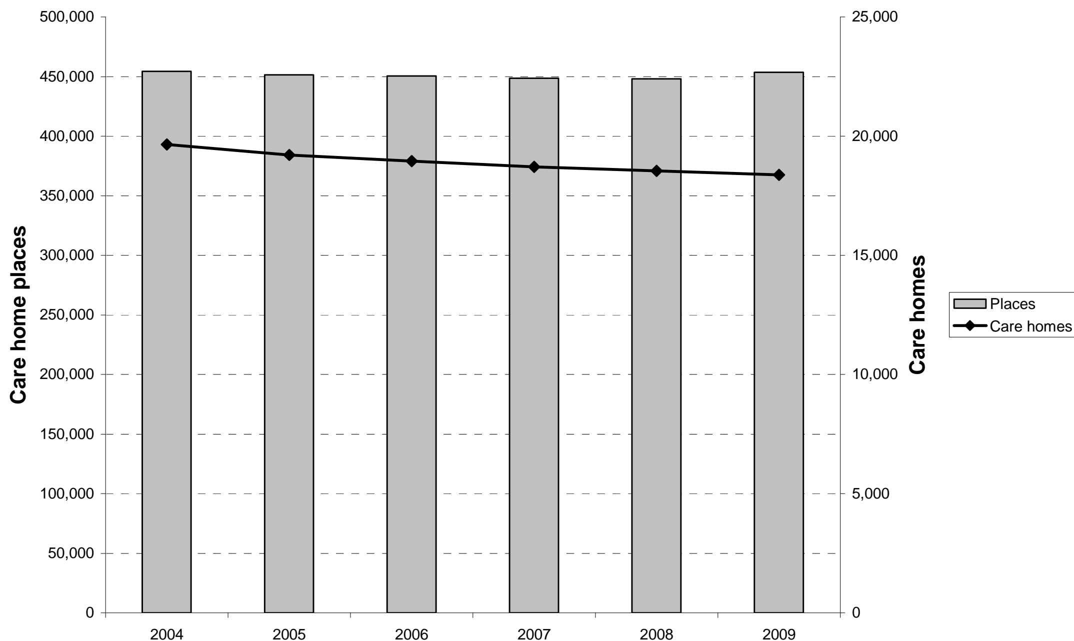
cost-effective. The better pay and conditions of staff in state owned homes usually make independent homes appear more economical, thereby ensuring further reductions of in-house services. Though the focus on 'best value' has waned with the emergence of the Comprehensive Performance Assessment, much of the regime is still in force.

Labour also created a new market of independent sector providers in the form of intermediate care. This sector is important as the reduction of NHS hospital beds has been justified on the grounds that hospital admission will be prevented with patients receiving intermediate care instead. The Care Quality Commission (CQC), which is the independent regulator of health and social care in England, cites that the amount of both non-residential and residential intermediate care available in England has risen significantly (CQC, 2010). However, figures are difficult to validate as they are not routinely published nor included in Department of Health statistics and, in any case, the Department has now abandoned their collection, justified in order to reduce the data burden.

Risks of outsourcing

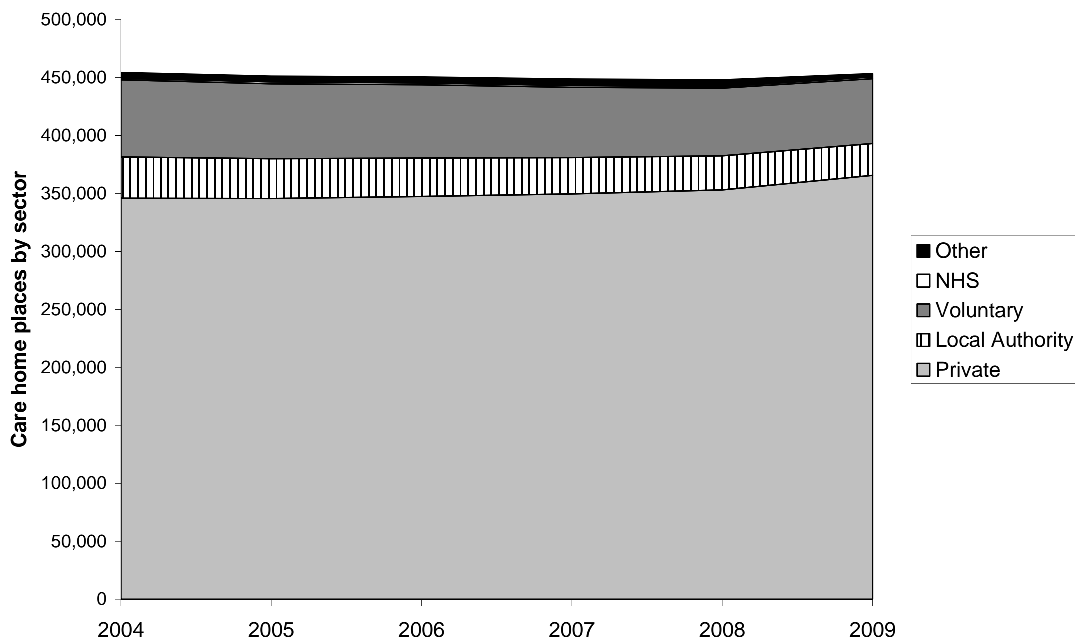
A major risk of relying on the independent sector is that there is nothing to prevent care home providers from simply closing down if the market changes which can be extremely serious for the health of their frail residents. Figure 2 indicates a reduction in the number of care homes (though not in places) in the last six years whilst Figure 3 shows how the proportion of places provided by the private sector continues to grow.

Figure 2 Numbers of care homes and places, 2004 to 2009, as at 31st March, 2010



Source: Care Quality Commission, 2009. Table A1.

Figure 3 Care home places by sector, 2004 to 2009, as at 31st March, 2010



Source: Care Quality Commission, 2009. Tables B1 to B6.

Regulation introduced in 2002 to protect residents from the more extreme effects of the market though the former regulatory body, the National Care Standards Commission, soon came under intense pressure from the care home lobby. By this time, local authorities depended on the independent sector to care for older people and the government made crucial concessions on staffing and building specifications, requiring only new homes to meet minimum standards that had been proposed in 1999, reprieving many registered substandard homes.

The introduction of a personalised adult social care system – consumer choice and control

Direct payments and personal/individual budgets

Direct (cash) payments are paid directly by councils to individuals assessed as eligible for services. The policy was pioneered by the 'young disabled' movement, a small, largely self-selected, relatively advantaged group compared with most who receive services. The concept originated in the US where they are known as 'vouchers' and were introduced in 1997 for working age adults, in 2000 to older people, and, in 2001 to parents and carers of disabled children. Since 2003, it has been a duty for councils to offer a direct payment as first option to eligible individuals able to provide consent with uptake a key performance indicator. The Health and Social Care Act 2008 extended direct payments to those unable to consent and those treated in the community under the Mental Health Act 1983, thereby applying the policy to society's most vulnerable people. But uptake has been slow. In England in 2008-09, 86,000 adults received direct payments and, despite annual increases, spend equated to just 4% of the overall gross current expenditure on care. They have been found more likely to be used by working age adults and there is wide variation in how much is paid (CQC, 2010).

In 2005, the main proposals of the government consultation paper on the future of social care *Independence, Well-being and Choice* (DH, 2005) included wider use of direct payments and the piloting of personal and individual budgets, justified on the premise that this would give individuals control and choice over their care. It discussed extending personal budgets (which are for social care only) to a range of other funding streams in order to improve the quality of services and stimulate the social care market, and to shift users from being passive recipients to active consumers of care. The subsequent white paper *Our Health, Our Care, Our Say* set out to implement these proposals as policy (DH, 2006). In turn, *Putting People First* (HM Government, 2007) set out a personalised adult social care system through a ministerial concordat on the 'transformation' of adult social care with a ring-fenced grant worth £520 million over three years, 2008-2011, to support the agenda (DH, 2008a).

However, the white paper explicitly ruled out extending individual budgets and direct payments to the NHS, stating that this would compromise the principle that care should be free at the point of need, whereas social care had always included means-testing and co-payment. Yet, two years later, the 2008 Darzi NHS review *High Quality Care For All* (DH, 2008b) used the premise of 'greater choice' to completely reverse this position, proposing expanding personal budgets to the NHS, prioritising people receiving continuing care or with long-term conditions. Subsequently, the previous government completed a consultation process as part of the review to extend direct payments to health care through legislation (DH, 2009).

So what is the future for social care?

The demographic time bomb?

Government policy for older people is invariably accompanied by warnings about the demographic time bomb, with those who are not economically viable living longer, commandeering services and placing an additional burden on the rest of the population as the ratio between those working and those who are retired reduces. The Labour Government expected that, in 20 years' time, 1.7 million more people in England would need care (HM Government, 2009), with the population aged over 65 projected to grow by almost half, and those over 85 to double. (CQC, 2010) This is seen as a problem because the age that people can expect to live without long-term illness or disability lags behind longevity. Presented in this context, a convenient argument is to propose that older people should provide for themselves, through savings, spend down of assets and insurance schemes. Therefore, despite huge increases in general standards of living, many are forced to sell their homes and spend most of the proceeds in fees before they can receive state-funded residential and social care (currently only after spend down to £23,000).

However, as pointed out by the House of Commons Inquiry this issue may be partially a transient 'cohort' effect due to the ageing of the population 'bulge' born post-war (baby boomers), who will not significantly affect demand for social care for 20 years, leaving time to prepare. Further, it is not inevitable that longer life expectancy means more years of ill-health given the work to develop effective treatments for long-term conditions as well as on preventive measures to counter risky health behaviours related to smoking, drinking, diet and exercise. Therefore, an ageing population does not inevitably lead to catastrophe provided informed decisions

are made and good planning is undertaken (House of Commons, 2010).

Personal budgets and direct payments

The transfer of the purchasing role from local authorities to individual consumers through individual budgets and direct payments leaves the most frail, elderly and long-term sick and disabled at the mercy of private providers with an unenviable record for quality and commitment. Some of the risks are:

1. Increasing inequalities in eligibility and access to services by creating a cash limit on what can be afforded and purchased locally. Despite personalisation agenda claims of providing choice and flexibility, individual budgets pass the risk of purchasing to the patient, many of whom will not want this burden. If entitlement to care is 'capped', patients would become effectively responsible for rationing their own care.

2. Cost inflation. Market systems are expensive to run with substantial administrative costs. Direct payments will inevitably reduce budgets, putting services at risk as has happened with independent sector treatment centres for elective surgery. This is bound to lead to reductions in capacity, particularly as direct payments cannot currently be spent on services directly provided by councils.

3. Social services departments could lose their skills, experience and economies of scale, leaving fewer, more expensive services for those too vulnerable to cope with the responsibility of direct payments. Though individual budgets may be held on their client's behalf, as social services focus on their purchasing role whilst expanding the private provider market, their capacity to manage care will reduce. The other safeguard is regulation and performance assessment but, as described, the record of governments to adhere to this does not inspire confidence following the back-down on standards for residential care in 1999.

4. Through the adoption of direct payments, the emergence of an unskilled, unregulated workforce of Personal Assistants directly employed by patients. The Labour white paper described plans to introduce a licensing scheme to apply to all social care workers and this is important to safeguard vulnerable patients.

In light of the Darzi announcement and government policy U-turn to extend individual budgets to the NHS, and the commitment by the new Coalition government to a greater use of direct payments and individual budgets, it seems only a matter of time before vouchers are introduced beyond social care to health care. These developments herald the loss of the collective consensus that the state has a duty to serve and protect the basic needs of all through population-based services, guided and sustained by a shared set of ethical and professional values.

A review of the National Care Service in light of administrative change

In light of the results of the general election it remains to be seen what is the likelihood of Labour's vision set out in *Building the National Care Service* coming to fruition. However, we briefly review some of concerns.

Absence of collective funding - In the absence of collective funding as a policy option, plans for a fairer system for funding care in old age are welcome. However, the white paper dismissed the option of meeting social care needs through a collective

system. Yet the tax-funded universal system has considerable support, perceived as the most equitable way to pay for care (House of Commons, 2010). This is the principle upon which health care is funded and there is no inherent reason why a National Care Service should differ from its counterpart NHS, however it has been organised in the past.

Timing and delay - The Labour government took three terms to address social care despite its stated intentions on coming to power. The timing of the white paper published so soon before the May general election ensured that there could be no changes until the subsequent parliament. Yet, surprisingly, it was announced at the 2009 Labour Party Conference that even though the consultation period had not ended, free personal care would be introduced for those with the highest levels of need cared for in their own home. This initiative raised concerns about unintended consequences as it only applied to people at home, plus there were important questions about the details of funding.

Free personal care for all – The National Care Service promises all adults in England with an eligible need, free care and support when they need it, wherever they live. However, for those in residential homes, this does not include accommodation which accounts for at least half of care home costs. The reforms include a deferred payments scheme to enable people to keep their home while they are alive, but the advantage of the scheme is questionable as charges on their estate after death will have the same effect in the end.

Replacement of mean-tested benefits - A controversial proposal of Labour's consultation on social care was the pooling of existing benefits with the general social care budget. The two main benefits, both paid by the Department of Work and Pensions, are Attendance Allowance (AA) and Disability Living Allowance (DLA). AA, which is the main non-means-tested benefit for people aged over 65 with disabilities, first came under scrutiny in the Wanless review (Wanless, 2006). Bringing these benefits, which could be regarded as the original direct payments, into the new NCS has been ruled out for now in the white paper, with funding for the new service envisaged to be from efficiencies and reform. Had the proposals been accepted, it was feared that benefits would become means-tested, cash-limited and rationed with criteria making it much harder to qualify, leaving many older people worse off, particularly those at the threshold of means-testing (the 'cliff-edge' effect) or needing just a small amount of help, adding to deprivation.

Eligibility criteria - A key issue is that of eligibility which the white paper promised would be determined against nationally consistent entitlements. But who would set these criteria and at what level of need, given that it is known that the level of entitlement rises progressively as resources become scarce? The Care Quality Commission's review of services in 2009 found that, in most councils (70%), people's needs must be substantial before they can get any publicly-funded social services support (CQC, 2010). The notion of eligibility criteria is also inherently at odds with the concept of a universal system.

Social care under the new coalition

The Conservative manifesto commits to increased personalisation and even greater use of direct payments and individual budgets. For older people, they propose a voluntary 'home protection scheme' which would involve pensioners paying a one-off £8,000 fee into a privately run insurance scheme that would ensure that all their residential care costs are covered. Prior to the new coalition, this scheme was condemned by the Liberal Democrats because two thirds of pensioners do not have this amount of assets unless they sell

their home. Further, the House of Commons Health Select Committee reported scepticism from the insurance industry about its feasibility (House of Commons, 2010). The prospect of a much needed consensus between the three major parties seems unlikely in view of reports of failed cross-party talks on social care late last year (Stratton, 2010). However, in the new era, agreement between at least two of the three parties might now be expected.

Summary

In summary, this review shows how, through a combination of rationing, charging and means-testing, the state has dispensed with much of its responsibility for social care leading to a system with wide variations in quality. Long-term care in particular has been neglected, paving the way for the domination of for-profit ownership since the 1980s. Many of the issues described here have been exacerbated by the internal market principles of separating the purchaser and provider function in both health and social care, rather than those of equity. This serves to fragment care, erode accountability and create a vacuum in planning for population health and social care needs. This is demonstrated by the lack of a framework for social care and the focus of the regulator on performance targets rather than on the development of good data collections to inform on planning and monitoring services.

So, with the advent of a new government, will the ambitions of *Building the National Care Service* come to anything? The white paper steered clear of addressing how the NCS was to be funded, except that the principles of the new service should be universal, accessible and based on need rather than ability to pay. Whatever the outcome, it is vital that this time the opportunity should not be missed to halt the cycle whereby successive governments have left social care chronically underfunded and taking low priority.

Acknowledgement

To David McCoy for his contribution to the critique of Direct Payments.

Appendix

Key developments in social care

1946 – National Health Service Act
1948 – Founding of the NHS
1948 – National Assistance Act – established that local authorities would provide basic residential accommodation to disabled and older people
1972 – Attendance Allowance introduced for disabled older people
1976 – Invalid Care Allowance introduced, later became the Carer's Allowance
1990 – NHS and Community Care Act made it a duty for local authorities to assess people for social care and created the internal market by separating purchaser and provider functions
1992 – Disability Living Allowance introduced
1996 – Community Care (Direct Payments) Act
1999 – Royal Commission on Long Term Care, recommended free personal care
2000 – NHS Plan rejected Royal Commission recommendation for free personal care
2001 – Health and Social Care Act enabled the creation of care trusts which combine NHS and council responsibilities across a number of areas
2002 – Free personal care introduced in Scotland
2006 – Wanless Social Care Review recommended a partnership funding option for older people's care with state funding a proportion, then individual contributions matched by the state
2006 – White Paper *Our Health, Our Care, Our Say* and statements in the 2007 budget report and Comprehensive Spending Review described a reformed adult social care system for England
2007 – *Putting People First*, ministerial concordat set social services on the course towards personalisation
2008 – *High Quality Care for All: NHS Next Stage Review,* Darzi, proposed extending personal budgets to the NHS
2009 – Green Paper *Shaping the Future of Care Together* consultation on proposals for reform and funding of social care
2010 – House of Commons Select Committee Report on Social Care, published March
2010 – White Paper *Building the National Care Service,* published March
2010 – May general election results in hung parliament, subsequently a Conservative/ Liberal Democrat coalition government

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