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An idea whose time has not yet come: Government positions on Long Term Care funding in England since 1999

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Abstract

This article seeks to explore ideas in Government Green Papers, and the Government appointed Commissions on Long Term Care funding since 1997 through the lens of the agenda-setting model of the Multiple Streams Approach. In particular, we examine the roles of ideas in the five major concepts of the model: the problem stream; the politics stream; the policy stream; the policy window; and the policy entrepreneur, for three key 'moments': the 1999 Royal Commission on Long Term Care for the Elderly, the 2009-10 Green and White Papers proposing a 'National Care Service', and the 2010-14 Dilnot Commission, White Paper, and the Care Act (Part 2). It is found that most of the documents discuss similar problems, similar policy options (although with different favoured options), and the need for some measure of political cross-party agreement (which has been undermined by cross-party sniping). However, the main obstacle seems to be perceived affordability. The efforts of the policy entrepreneurs have not, as yet, resulted in the policy window, ajar for over twenty years, being fully opened. In short, Long Term Care funding represents an idea whose time has not yet come, with discussions dominated by cost, meaning that the ideas have been on the agenda – but not seriously on the agenda.

Keywords: Long Term Care, funding, England, agenda-setting, Multiple Streams Approach, ideas

Introduction

In his first speech as Conservative Prime Minister Boris Johnson clearly stated his aim to finally come up with a solution to one of the great policy failures of the last 20 years: 'My job is to protect you or your parents or grandparents from the fear of having to sell your home to pay for the costs of care… And so I am announcing now… that we will fix the crisis in social care once and for all, and with a clear plan we have prepared to give every older person the dignity and security they deserve' (Campbell, 2019).

This has a feeling of 'Groundhog Day', as over twenty years ago, Labour Prime Minister Tony Blair's first speech to the Labour Party Conference stated that 'I don't want [our children] brought up in a country where the only way pensioners can get long term care is by selling their home'. The 1997 Labour Party Manifesto made a commitment to establish a Royal Commission on Long Term Care for the Elderly. However, the Labour government rejected the main recommendation of that Royal Commission, of free personal care, (although it was introduced in Scotland in 2001) (see e.g. HoCL, 2017). Humphries (2013) writes that there have been two independent Commissions, three Consultations, five White and Green Papers and innumerable reports from think tanks, charities and other organisations. However, despite all these documents, the essential features of the system remain unchanged (House of Commons Library [HoCL], 2017).

The most cited model of agenda-setting in academic literature is Kingdon's (2011) *Agendas, Alternatives and Public Policies*, often termed the 'Multiple Streams Approach' (MSA) (see Jones *et al*., 2016). MSA is said to have five major concepts—three 'streams' of problem, politics and policy; policy window; and policy entrepreneur. The independent problem, political and policy streams at times are 'coupled' during fleeting opportune times called 'policy

windows' (Jones *et al*., 2016). Kingdon (2011, p.178) argues that the probability of an item rising on the decision agenda is dramatically increased if all three streams are joined. If one of the three elements is missing – if a solution is not available, a problem cannot be found important or is not sufficiently compelling, or support is not forthcoming from the political stream – then the subject's place on the decision agenda is fleeting and fades from view. He goes on to argue that the policy entrepreneur provides the necessary dose of agency required to couple the streams and shape policy outputs. He writes that three qualities contribute to the success of policy entrepreneurs: some claim to a hearing (expertise, an ability to speak for others, and an authoritative position); political connections or negotiating skill; and 'probably most important', persistency (Kingdon, 2011, pp. 180-181).

A number of scholars have stressed the importance of 'ideas' in Kingdon. For example, Mehta (2011) argues that his work remains the touchstone for any theoretical discussion about the role of ideas in the policy process. According to Greer (2015), ideas are vitally important in *Agendas, Alternatives and Public Policies*, and have a much more stable and definable position than in many theories. Béland (2016) writes that although it is not primarily a book about ideas, it provides significant insight about their role in agenda-setting, with the term 'idea' appearing in the text 82 times in total.

This article seeks to explore ideas in Government Green Papers, and the Government appointed Commissions on Long Term Care (LTC) funding since 1997, through the lens of MSA. In particular, we examine the roles of ideas in the five major concepts of the model (above). While there have been several independent enquiries (notably the King's Fund 'Wanless' Social Care Review), and related policy developments regarding eligibility, charging and marketisation (HoCL, 2017), for the sake of space and clarity, we have focused on understanding government produced or commissioned documents concerning the overall funding settlement. We also narrowed our investigation to English proposals, given the divergence of funding policy in the UK following the establishment of the Scottish, Welsh and Northern Irish assemblies and governments. This set of criteria leaves us with three key 'moments':

- The 1999 Royal Commission on Long Term Care (RCLTC) for the Elderly, chaired by Professor Sir (now Lord) Stewart Sutherland, which proposed 'free personal care'.
- The 2009-10 Green and White Papers proposing a 'National Care Service'.
- The 2010-14 Dilnot Commission, Green Paper, Care Bill and Care Act (Part 2) proposing a 'cap and floor model'.

The framework of our approach

The structure of this paper is as follows. First, we discuss the role of ideas in MSA. This is followed by a brief chronology of recent Government Green Papers, and the UK Government appointed Commissions on LTC funding since 1997. The following sections explore ideas in relation to the five major concepts of MSA, before turning to a final section that sums up the paper's argument and conclusions.

Kingdon and ideas

Ideas appear at a number of points in Kingdon's text. He discusses how ideas float around in the 'policy primeval soup', arguing that within the policy communities, many ideas are considered at some stage and in some way, and that policy entrepreneurs are advocates for proposals or for the prominence of an idea (pp. 121-122). Policy entrepreneurs attempt to 'soften up' both policy communities and larger publics, getting them used to new ideas. The criteria that enhance the odds of an idea's survival include technical feasibility and value acceptability, which are internal to the policy community; but others, such as tolerable cost, anticipated public acquiescence, and a reasonable chance for receptivity among elected decision makers, exist in the larger political arena (p.131). He claims that a policy community

produces a short list of ideas, but few ideas emerge as the leading candidates for further serious consideration (p.139). When the policy window opens, ideas must have gone through a 'long process of consideration, floating up, discussion, revision, and trying out again' (p.141).

Béland (2010, 2016) examines ideas which roughly correspond to Kingdon's problem, policy, and political streams. For example, Béland (2010) discusses respectively ideas as understanding of policy issues and problems; ideas as assumptions that guide the development and the selection of policy alternatives; and ideas as framing processes that help actors legitimize particular policy decisions. Similarly, Mehta (2011) considers ideas at three levels of generality: policy solutions, problem definitions, and public philosophies or zeitgeist.

Long Term Care in the recent past

The system for funding LTC inherited by the Blair government emerged from the post-war settlement and its separation of health and welfare services, with the former being delivered largely free at the point of use, on the basis of need, by the National Health Service (NHS); and the latter delivered (or commissioned) by local government, with access determined by means and needs testing. In 1997, individuals with more than £16,000 capital were ineligible for state support (which included the value of their homes if they entered residential or nursing care, but not if a partner was living there), those with between £10,000 and £16,000 were partially charged for services, and only those with under £10,000 received full, free, state care. In addition, local government was not compelled to support those whose needs they considered ineligible according to locally determined needs-tests. This section presents a timeline of key events (taking into account our criteria established above) since 1997 (e.g. Humphries, 2013; HoCL, 2017; Wenzel *et al*., 2018).

Following a manifesto commitment, the Labour Government established a Royal Commission on Long Term Care for the Elderly, chaired by Professor Sir (now Lord) Stewart Sutherland. The Secretary of State for Health announced the Royal Commission in December 1997, rejecting the 'value acceptability' of the current arrangements: 'The present situation cannot go on much longer. People are entitled to security and dignity in their old age, so we must find a way in which to fund long term care which is *fair and affordable* both for the individual and for the taxpayer' (Hansard, 4 December 1997, cols. 489-90, our italics). In a theme that shaped the path for the next twenty years, the terms of reference for the Royal Commission stressed tolerability of costs, using terms such as having regard for 'constraints on public funds', the 'deliberations of the Government's comprehensive spending review', and the need for 'costed' recommendations (RCLTC, 1999).

The Royal Commission reported in 1999, with a majority report advocating free personal care, but a note of dissent by two of the 11 Commissioners rejected the main tenets of the report on the basis of the intolerability of costs. It is also likely that political acquiescence and technical feasibility came into play: Sutherland, in an interview with *The Guardian* in 2009 described 'a campaign that had this unholy alliance of special advisers, folks who always took the Treasury outlook – never take on any spending commitment you can avoid' (Brindle, D., *The Guardian*, 25 February 2009).

The Government response (Secretary of State for Health, 2000, p.5) stated that a fairer and more sustainable balance between taxpayers and individuals must be found for the funding of long term care, that it be brought into line with 'NHS principles', and that people should not have to sell their homes to fund care. However, the Government did not accept Sutherland's central recommendation of 'free personal care', believing that the funds necessary could be deployed more effectively in services. Stressing the 'very substantial cost' of free personal care, it cited the Note of Dissent to the Royal Commission's report that this recommendation would not help the least well off, arguing that its 'alternative proposals' were preferable (Secretary of State for Health, 2000, p.11).

In 2003, the nine Royal Commissioners who had signed the Majority Report issued a statement (Royal Commissioners, 2003), pointing out that nearly five years after the report, 'little has been resolved. Governments in most of the United Kingdom still decline to act'. It argued that the lack of action with respect to the funding of free personal care was 'regrettable', which was 'all the more so because governments appear to have rejected the Commission's recommendation essentially on grounds of lack of affordability (tolerable cost) rather than lack of value acceptability'. Pointing to a 'policy vacuum', it continued that:

> *It is interesting to note that, while the Government's 1997 Manifesto spoke of a 'fair' system of Long Term Care funding, the Government's response to the Royal Commission Report claimed merely to be introducing a 'fairer' system. There is a world of difference between the two* (pp. 5-6).

This change of framing relates to Mehta's conceptualisation of 'policy definition' in Kingdon.

Under the new Labour Prime Minister Gordon Brown, a Green Paper *Shaping the Future of Care Together* (Secretary of State for Health, 2009) launched the 'Big Care Debate', a public consultation on how social care should be funded and organised. The Government proposed a 'National Care Service', with five options for funding, but favoured the partnership model where the state would cover a specific (to be determined) proportion of costs, with individuals and their families covering the remainder.

This was followed by a White Paper, *Building the National Care Service* (Secretary of State for Health, 2010). The Government proposed that, for England, there would be three steps towards creating a system of free social care: from 2011, 'around 280,000 people with the highest needs will receive free personal care in their own home'; from 2014, 'anyone staying in residential care for more than two years will receive free care after the second year'; and subsequently there would be the introduction of a National Care Service, free-at-the-point-of-use, for all adults in England (Secretary of State for Health, 2010, pp. 8-9).

The proposed two-year limit on paying for social care for care home residents was similar in nature (but of a shorter duration) to that considered (but not recommended) by the 1999 Royal Commission. Although under step three of the proposals, social care would be free at the point of use, the Government expected that 'people will continue to pay for their accommodation costs in residential care if they are able to do so'. There would also be a deferred payment scheme, to enable people to retain their homes. This would be available to those whose capital fell below £23,000 (excluding the value of their home). The White Paper explained that, 'after carefully considering the results of the Consultation, the Government has concluded the National Care Service should be based on the approach that received the greatest public and stakeholder support (public acquiescence and political feasibility) – the Comprehensive option'. During the following 2010 election campaign, the Conservatives had produced a 'Death Tax' poster, alleging that during cross-party talks Labour had proposed a levy of £20,000 on all estates. The election produced a hung parliament and the formation of a Conservative/Liberal Democrat Coalition Government. Kingdon's political stream was notably absent on this occasion.

The Coalition Government stated that it would establish a Commission on LTC, to report within a year, which would consider a range of ideas, including both a voluntary insurance scheme to protect the assets of those who go into residential care, and a 'partnership' approach. It appointed the Dilnot Commission in 2010, which recommended changes to the means test and a capped cost model (Commission on Funding of Care and Support, 2011). A White Paper, *Caring for Our Future: Progress Report on Funding Reform* (Secretary of State for Health, 2012) was followed by a draft Care and Support Bill.

The Government agreed that the principles of the Commission's model would be the right basis for any new funding model – financial protection through capped costs and an extended means test. However, 'due to costs, it was unable to commit to introducing the new system at this stage' (Secretary of State for Health, 2012, p.6). Again, the political stream was missing, framed in terms of tolerable cost, with the Government's commitment to reducing public expenditure taking priority.

The Government proposed further consultation, with the policy to be set out in the next spending review. The White Paper did note that among stakeholders 'there was discussion of the level of the cap, with some people suggesting that a cap could be set at the top of the Commission's range – or even slightly higher (e.g. at £75,000) – without undermining the principles of the system' (*ibid*., p.14).

The Care Act 2014 implemented a less generous version of the Dilnot proposals, setting a cap at a level of £72,000, an upper capital limit at £118,000 for care home residents and £27,000 for those receiving care at home. The lower capital limit would be raised from £14,250 to £17,000. However, this part of the Care Act was never implemented, trumped by 'austerity' (HoCL, 2017).

The May 2015 General Election saw a new Conservative Government in power, and the Conservative Party's election manifesto had made a commitment to implement the cap from April 2016. However, in July 2015 the Government announced that it would delay reform of how people pay for social care from April 2016 to April 2020. Significant controversy surrounded the Conservative manifesto for the May 2017 General Election, with interpretations of the cap being dropped, and the proposals being labelled a 'dementia tax' much in the same way Brown's plans were labelled a 'death tax', although the Prime Minister Theresa May insisted that 'nothing has changed'. The fiasco over LTC reform apparently contributed to a significant reduction in electoral support for the Conservatives, and the subsequent minority government announced that it would no longer be taking forward plans to implement a capped cost care model by 2020. In short, little has changed since the Royal Commission of 1999, leading to the 'Groundhog Day' (above) of a new Prime Minister in 2019 promising to solve the problem of LTC.

Ideas and the problem stream

Kingdon (2011) is well aware that within the problem stream, not all 'issues' or 'conditions' become 'problems', and that indicators need to be interpreted. He argues that conditions come to be defined as problems due to values, comparisons and categories. For example, he discusses how conservatives and liberals may differ on whether a given income distribution might be regarded as a problem of poverty. He discusses how some conditions become problems through 'indicators', which are seen as providing quantitative and qualitative information on a condition, and through 'focusing events' which are jarring and sudden and become attached to particular problems. The reports discussed below produced many indicators, and focused attention (albeit temporarily) on the issue of LTC.

The Royal Commission (1999) was keen to stress the 'opportunities and challenges' rather than the 'problem' of ageing. However, it pointed out that society would be ageing, and outlined the five most important factors which affect the future demand for and costs of LTC: demography; health expectancy; the supply of unpaid care from families, relatives and friends; use of services; and care costs. It was 'quite clear' that 'there is no such thing as a do-nothing option' (para 10.4). The Government Response (Secretary of State for Health, 2000) noted too that we live in an ageing society, and that people were living longer.

The 'Foreword by Secretaries of State' to *Shaping the Future of Care Together* (Secretary of State for Health, 2009) pointed out that the current care and support system was designed in

the 1940s and we need to develop a system that fits our needs in the 21st century, arguing that a system that is fairer, simpler and more affordable for everyone was needed.

After the almost obligatory reference to Beveridge, the Secretary of State for Health (2010) noted that the current social care system was designed for a different era and cannot cope with the challenges of today. The current system, in which people are expected to pay for their care if they can afford to do so, simply cannot cope with anticipated pressures and presents an unacceptable uncertainty which private insurance markets cannot respond to. Without reform, the system will quickly become unsustainable and many more people will go without the care they need or risk losing their homes to pay for their care.

The document discussed 'the case for change' and 'challenges with the current system'. It noted the current problems with the system, but also argued that over the next 20 years we will see new challenges on a scale that care and support has never had to grapple with: demographic changes; changes in technology; changing expectations; and economic conditions. It pointed to geographical inequalities: people with the same needs receive different levels of care depending on where they live. The system was confusing, and there is no way of predicting what a person's care costs will be, leaving everyone at the potential risk of catastrophic care costs.

In his 'Foreword' (Commission on Funding of Care and Support, 2011, p.3), Dilnot stated that 'our system of funding of care and support is not fit for purpose and has desperately needed reform for many years. …Now is the time to act'. Dilnot also repeated the themes of growing demand due to ageing and identified LTC as an uninsured risk of modern life which exposes people to potentially massive costs. He too identified the complexity and confusion facing those who attempt to get state support. The Secretary of State for Health (2012) largely repeated the Dilnot Commission's case for change, and its main arguments made in support of reform.

In short, most of the documents (and related political discourse) point to similar issues:

- demand due to an ageing population,
- the complexity and uncertainty faced by those with care needs and their families,
- the inadequacy of the current system to insure against huge costs,
- the unacceptability of the impact from a values perspective: having to lose savings, sell your home and forgo an inheritance for your children,
- the urgency of action to address the above.

If the system was outdated, with 'no such thing as a do-nothing option' (RCLTC, 1999, para 10.4) in 1999, the need for action must presumably be greater now some twenty years later. While these indicators have consistently jolted governments to consider LTC funding a problem, policy formation has been more difficult.

Ideas and the policy stream

The Royal Commission (1999) discussed three very broad options: voluntary private insurance; compulsory social insurance; and state collective provision, along the lines of the NHS (para 3.9). It favoured the third option, of universal risk pooling (para 3.16). In the chapter 'Improving Public Provision', it set out six options for change. One of these discussed, but not favoured, was essentially a 'cap' (although the term was not used) of 'limiting liability to pay for four years' as a way of alleviating the impact of the means test (para 6.21). Having rejected the first five options as 'little more than tinkering with the means-testing system' (para 6.27), it settled on the sixth option of 'a major restructuring of the payment system for residential care', which would make state financial support more universal than now. This meant that 'the Commission's main recommendation is that personal care should be available for those individuals who need it, after an assessment' (para 6.37). To finance this, it favoured a 'pay as you go' system based on general taxation, rather than a hypothecated (or 'ear marked') levy (paras 6.67, 6.71).

This is the specific policy element rejected by the minority commissioners. In their view, this represented an 'alarming' cost, which involves a 'huge transfer of expenditure from the private to the public purse over a period when the public purse is likely to be severely stretched' (Note of Dissent, Royal Commission on Long Term Care, 1999, paras 27, 28). Their objection takes in Kingdon's categories of tolerable cost and technical feasibility on behalf of the state.

The Government Response (Secretary of State for Health, 2000) supported the position of both the majority and minority reports that nursing care should be available free under the NHS to everyone in a care home who needs it. Reflecting the minority view, it rejected making personal care free for everyone, as it 'carries a very substantial cost, both now and in the future', but:

> *Would not necessarily improve services, as the Note of Dissent to the Royal Commission's report makes clear. It does not help the least well-off. We have not followed this recommendation because we believe our alternative proposals to improve standards of care and fair access to services will generate more important benefits of health and independence for all older people, now and in the future* (p.11).

According to the Secretary of State for Health (2009), the policy solution was to 'build the first National Care Service in England'. It outlined five ways in which the National Care Service (NCS) could be funded. First, a 'Pay for Yourself' model was ruled out as being 'fundamentally unfair'. Second, the 'Partnership' model involved everyone who qualified for care and support from the state being entitled to have a set proportion – for example, a quarter or a third – of their basic care and support costs paid for by the state. People who were less well-off would have more care and support paid for – for example, two-thirds – while the least well-off people would continue to get all their care and support free of cost. Third, 'Insurance' sees everyone entitled to have a share of their care and support costs met, as in the Partnership model. However, if they wished, additional costs of their care and support would be covered through private or state insurance. Fourth, the 'Comprehensive' model would require everyone over retirement age with the resources to do so paying into a state insurance scheme. Everyone who was able to pay would pay their contribution, and then everyone whose needs meant that they qualified for care and support from the state would get all of their basic care and support free when they needed it. Fifth, a 'Tax-funded' model was ruled out because it places a heavy burden on people of working age. The government proposed that the Partnership model should be the foundation of the new system.

Turning to accommodation costs, the Government stated that it was fair to expect the majority of people to meet these costs themselves. It proposed a 'universal deferred payment mechanism', allowing residential care and accommodation costs to be charged upon a person's estate when they die, rather than having to go through the process of selling their home when they need residential care.

Not for the first time, the 'White' Paper (Secretary of State for Health, 2010) seemed to be fairly 'Green', in that it kicked the can down the road. It stated that:

> *At the start of the next Parliament, we will establish a commission to help to reach consensus on the right way of financing this system. The Commission will consider all the options for payment put forward by charities and the public as part of the Big Care Debate and at the Care and Support Conference* (p.4).

However, without using the term, it did suggest the idea of a 'cap': while it would take time to fully deliver the vision of a universal NCS, free when people need it, 'from 2014, anyone staying in residential care for more than two years will receive free care after the second year' (Secretary of State for Health, 2010, p.5). It stated that the Government was committed to a NCS in which everyone was protected against the costs of care, and in which no one needed to lose their home or their savings to meet these costs.

So while retaining individual contributions and a long term and iterative implementation process, the Government claimed the NCS would be based on the approach that received the greatest public and stakeholder support – the Comprehensive option:

> *We think it is right that society takes collective responsibility for sharing care costs, in a way that will give people peace of mind and will allow them to plan properly for later life. For this to be affordable requires a care system in which everyone contributes, through a fair care contribution. Under a comprehensive NCS, the Government expects that people would continue to pay for their accommodation costs in residential care* (p.24).

The Dilnot Report (Commission on Funding of Care and Support, 2011) discussed a range of different approaches to pooling risks so that people have protection against high care costs, but rejected both private insurance and a full social insurance scheme, eschewing the universalist discourse of the NCS proposals. It proposed a 'capped cost model', with the cap between £25,000 and £50,000. It estimated that the recommended changes to the funding system would cost from around £1.3 billion for a cap of £50,000, to £2.2 billion for a cap of £25,000. It stated that a cap outside this range would not meet criteria of fairness or sustainability and suggested a cap of £35,000. After reaching the cap, people should continue to pay general living costs such as food, heating and accommodation. The Commission believed that a means-tested system should continue alongside the new capped cost element and recommended that the upper threshold within the residential care means test should be raised from £23,250 to £100,000.

According to the Secretary of State for Health (2012), the Government agreed that the principles of the Commission's model would be the right basis for any new funding model – financial protection through capped costs and an extended means test. However, for reasons of cost, it was unable to commit to introducing the new system but would come to a final view in the next spending review. It would take forward some of Dilnot's other recommendations. For example, it would introduce a right to a deferred payment scheme for residential care. It would also introduce for the first time a national eligibility threshold for adult care and support in England, as set out in the accompanying White Paper.

Ideas and the politics stream

In broad terms, the political right has favoured means-testing, while the political left has favoured universality, such as the risk pooling of the NHS. However, it is generally agreed that making changes to the financing of LTC requires some degree of cross-party agreement. Moreover, several documents, such as those cited above, have stressed the value of public debate and stakeholder engagement.

The Royal Commission (1999, para 11) stressed they were in search of a series of proposals which would give due weight to issues such as fairness, efficiency and effectiveness. Their 'framework for evaluation' included issues such as fairness; maximum choice, dignity and independence; security, sustainability, adaptability; quality and best value. The main proposal of free personal care was based on considerations of both equity and efficiency. First, it focused on the issue of 'diagnostic equity': 'whereas the state, through the NHS, pays for all the care needs of sufferers from, for example cancer and heart disease, people who suffer from Alzheimer's disease may get little or no help with the cost of comparable care needs' (para 6.33). Free personal care 'would go a long way to making services provided for long term care as valued and as jealously guarded as those provided by the National Health Service. The principle of equal care for equal needs would be properly recognised for the first time' (para 6.35). Second, from the point of view of efficiency, the Royal Commission considered that the extension of universality, through the collective approach entailed by the proposal, was the most efficient way of covering the risks of having to meet LTC costs (para 6.36).

The Labour response to Sutherland (Secretary of State for Health, 2000), while stressing principles of 'fair access' and 'fairer' (p.20, rather than 'fair') funding, rejected free and universal personal care, in the name of making the best use of resources.

Almost a decade later, Prime Minister Gordon Brown (Secretary of State for Health, 2009) stated that the way in which our society provides care and support for those who need it, whether in later life or because of disability, should reflect our values of compassion and fairness. The NCS, in his view, was fundamental to that vision, addressing the unfairness of postcode lotteries and providing greater security for all in their later years.

The following year, Brown (in Secretary of State for Health, 2010) explicitly compared the NCS to Labour's achievement of the NHS. He pointed to a 'bold, ambitious reform to create a system rooted firmly in the proudest traditions of our NHS' (p.2). However, it can be seen that while the NCS would probably have increased 'nationalness', by reducing the 'postcode lottery', only the rejected option of tax funding and being free at the point of use would have approached a 'bold' NCS, similar to the NHS. For all the talk of 'fundamental change', 'radical reform', and 'new chapter in the story of our welfare state', the Bevan model had been ruled out the previous year.

In addition to reflecting ideological choices, the Secretary of State for Health (2010) was keen to root the reform in the 'national mood' as reflected in the 'Big Care Debate', which involved over 68,000 people taking part, making it the largest consultation ever on care and support: 'people told us that the time for reform has come' (p.4).

The Dilnot Report (Commission on Funding of Care and Support, 2011) stressed the importance of 'shared responsibility' (i.e. not like the NHS), pooling of risk, and 'fairer funding'. The Secretary of State for Health (2012) reported stakeholder engagement which showed that the majority of those involved in the engagement supported the Dilnot Commission's proposals for a cap. Turning to the level of the cap, it was generally felt that the cap could be set at the top of the Commission's range. However, the financial services industry considered that a cap at the top end of the recommended range or higher would be appropriate, and other [unnamed] stakeholders had suggested that even higher levels of cap (e.g. £75,000) should be considered (p.20).

Ideas and the policy window

As noted above, Kingdon (2011) argues that the policy window opens when the three streams come together. In some ways, the policy window has been open, or at least ajar, for over twenty years. The problems have remained, and arguably intensified, and the windows are 'political', opened largely by elections or new governments. However, it seems that windows on a resolution of care and cost issues in adult social care have been closed, largely due to issues of cost. The Sutherland window was closed because of affordability. The issue reached the legislative stage in the form of a Labour draft Bill around 2010 and elements of the Coalition's Care Act of 2014. However, neither were implemented, due to a change of government and backtracking respectively.

Ideas and policy entrepreneurs

The obvious policy entrepreneurs are the Sutherland and Dilnot Commission chairs, along with their fellow commissioners (including the Sutherland dissenters and the 'unholy alliance' briefing against them) (Brindle, 2009). As noted above, (most of) the Royal Commissioners of 1999 took the unusual step of issuing a statement nearly five years after the Commission's Report. Dilnot has also maintained an interest in the topic. There is little reference in the White and Green Papers or Commissions to other policy entrepreneurs, which suggests a very limited degree of policy learning, and much discussion on 'reinventing the wheel'.

Discussion and conclusions

It can be seen that most of the documents discuss similar problems (**Figure 1**), although as the population continues to age, they become more urgent. The documents have produced a broad discussion of similar policy options, although with different favoured options. Sometimes an option rejected in a previous document has been revived. Conversely, a favoured option in an earlier document has sometimes later been rejected. However, there appears to be little 'organisational memory' or policy feedback, in that there are few references to previous documents. The main problem appears to be cost.

Figure 1. Policy documents: contents and Kingdon's policy schema.[1]

	Problem Stream	**Policy Stream**	**Political Stream**	**Policy Window**	**Policy Entrepreneurs**
RCLTC (1999)	'Opportunities and challenges' rather than the 'problem' of ageing. However, in future society will be ageing, and the future demand for and costs of LTC will rise.	Free personal care, but continuing accommodation costs.	Manifesto commitment to set up Royal Commission.	'Quite clear' that 'there is no such thing as a do-nothing option'.	Majority and Minority Commissioners.
SSH (2000)	We live in an ageing society.	Rejected majority view of free personal care.	Stressed principles of 'fair access' and 'fairer' (rather than 'fair') funding; NCS but rejected free and universal personal care.	Commitment to vague 'alternative proposals'.	
SSH (2009)	Outdated system; rising life expectancy and care costs; uncertainty; unfairness (post code lottery).	Discussed five options: 'Pay for Yourself' (rejected); 'Partnership'; 'Insurance'; 'Comprehensive'; 'Tax-funded' (rejected). Favoured 'Partnership'.	NCS intended to invoke NHS; reflects values of compassion and fairness.	NCS to be phased in over a number of years. 'A White Paper will be published in 2010'.	
SSH (2010)	Care system was designed for a different era. Problems of demographic changes; changes in technology; changing expectations; and economic conditions increasing over next 20 years.	Series of stages, including two year 'cap' from 2014. Favoured 'comprehensive' option (but with funding issues yet to be decided), and some to pay accommodation costs.	As 2009.	Due to be implemented after 2010 Election, so window closed.	

[1] 'SSH' is 'Secretary of State for Health'

	Geographical inequalities; confusing system.				
CFCS (2011)	Current system is confusing, unfair and unsustainable, with a major problem that people are unable to protect themselves against very high care costs. System of 1948 is not fit for purpose in the 21st century and is in urgent need of reform. Geographical inequalities: 152 different systems.	Rejected both private insurance and a full social insurance scheme. Proposed a 'capped cost model', with the cap between £25,000 and £50,000. Extended means test, with upper threshold raised from £23,250 to £100,000.	Cost-pooling.	Stressed urgency: 'Now is the time to act'.	Dilnot has also subsequently urged action.
SSH (2012)	As 2011.	Broadly accepted Dilnot funding model – financial protection through capped costs and an extended means test. However, for reasons of cost, it was unable to commit to introducing the new system at present. Agreed the recommendation of a universal system of deferred payments for residential care.	Agreed principles of the Commission's model would be the right basis for any new funding model.	Delayed due to cost.	

Ideas in the politics stream contain a mix of ideology, public opinion and stakeholder engagement, and the need for some measure of cross-party agreement. However, any cross-party agreement was made difficult by accusations of imposing a 'death' or 'dementia' tax. Although Labour draws on broad ideological support for universality, and attempts to draw parallels with Bevan's NHS, its ideas in the policy stream have not always matched these. Despite its suggested NCS clearly attempting to invoke comparisons with the NHS, the NCS does not appear to match the principles of the NHS as being largely tax-funded and free at the point of use. All Labour arguments against tax funding would have applied to the 1948 NHS, but similar arguments from opponents were overruled by Bevan, despite policy implementation being at a time of great austerity. Similarly, the traditional Conservative favouring of means-testing has been blurred by the electoral imperatives of not alienating supporters facing large care bills and selling assets such as houses. The efforts of policy entrepreneurs have not led to the opening of the policy window in the form of implemented legislation.

After the decisive Conservative victory in the General Election of December 2019, it appears that Prime Minister Boris Johnson will be in office long enough to implement his promise; but the statement of the Secretary of State for Health in 1997 that 'the present situation cannot go on much longer' has resonated for over 20 years; and thus the entitlement of older people 'to security and dignity in their old age' (Hansard, 4 December 1997, cols 489-90) represents an idea whose time has not yet come. In short, it seems that ideas on LTC over the last twenty years or so have been dominated by cost, meaning that the ideas have been on the agenda – but not seriously on the agenda.

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