Institute for Public Policy Research

SOCIAL CARE: FREE AT THE POINT OF NEED

THE CASE FOR FREE PERSONAL CARE IN ENGLAND

Harry Quilter-Pinner
and **Dean Hochlaf**

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ABOUT THIS PAPER

This paper sets out new research and bold policy proposals which aim to address the growing crisis in social care. In line with IPPR's charitable objectives, its recommendations aim to improve the efficiency of health and social care services in England by joining up health and social care policy and delivering a more preventative model of care. They also aim to advance the physical and mental health of those with social care needs by ensuring that everyone – regardless of means – receives adequate and appropriate support.

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SUMMARY

1. **While the NHS has been protected since the financial crisis, social care has faced significant funding cuts.** This is having severe consequences in the sector. There has been a staggering 5 per cent drop in the number of people receiving publicly funded social care per year – totalling around 600,000 people since 2010 – despite an ageing population (Darzi 2018). The cuts are also beginning to impact on quality, particularly as a result of workforce pressures – with high turnover and huge staffing gaps. Meanwhile, provision in the sector is becoming increasingly unstable as a growing number of providers struggle to survive.
2. **The divide between the NHS and social care is increasingly unsustainable.** Since 1948, a boundary has existed between the NHS and social care. This boundary has given rise to four key fragmentations in entitlements, funding, commissioning and provision (Barker 2014). Unsurprisingly, this has contributed to fragmented and uncoordinated care, which is particularly problematic as more and more people get older, live with complex needs, and require both regular health and social support. These fragmentations also lead to inefficiencies in provision such as delayed transfers of care and avoidable admissions to hospital.
3. **The government must urgently overcome a legacy of failure on social care and 'grasp the nettle' of reform to avoid the collapse of the social care system.** There have been multiple limited attempts at social care reform over the last few decades, but none have managed to overcome the toxic combination of a lack public understanding about the system, a disempowered workforce and vulnerable user group to deliver lasting change. The government now has another opportunity to resolve this challenge, having committed to publishing a green paper on the topic followed by concrete actions to deliver lasting change. They must now 'grasp the nettle'.
4. **In order to improve the efficiency of public services, advance health and relieve poverty, we recommend the introduction of a bold and comprehensive reform package in three key steps**:
    - **Step 1: Introduce free personal care in England for over 65s.** This would mean that the care element (as opposed to the accommodation element) of social care would become free at the point of need. This change would in effect, redraw the boundary of the NHS – or at least extend the principles underpinning it - to include elements of social care. This would create parity between dementia patients and those living with other long-term conditions. It would also enable the creation of a more integrated and joined-up system. It would also more than double the number of people receiving state funded social care meeting previously unmet need and reducing pressure on carers. Furthermore, free personal care is simpler and more popular with the public than the alternatives proposed (eg Dilnot 2011), with almost three-quarters of the population supporting it (Independent Age 2018b). Such a policy would also almost halve the number of people facing catastrophic care costs from around 140,000 people to 80,000. For those still facing catastrophic social care costs there may be a case for a cap on care costs which (if set at £85,000) we estimate could cost between £3.2 billion (for everyone) or as little as £350 million (for only those people with assets of £200,000 or less). An alternative approach would be to introduce a more generous means-test.

- **Step 2: Fully fund free personal care.** Free personal care would require social care spending to increase from £17 billion per annum today to £36 billion by 2030 (excluding the cost of a cap or more generous means test). This is not cheap but would still represent an increase of less than 1 per cent of total government expenditure, 7 per cent of NHS spending and is only marginally more expensive (£2 billion in 2030) than the Conservative party's 2017 election pledge of a cap and floor system. The local tax base is neither fair nor sufficiently deep to raise this amount of money. Likewise, raising tax revenues from wealth is politically challenging and has often been a stumbling block for social care reform. We therefore recommend that free personal care is fully funded out of general taxation, requiring either a 1.31 percentage point increase in national insurance or 2.11 percentage point increase in income tax (Independent Age 2018a).
- **Step 3: Join up health and social care.** To fully unlock the benefits of free personal care it must be combined with fundamental reform in the model of care provided across the country, with a focus on delivering more joined-up, preventative, accessible and personalised care. After all, more care is only valuable if it's also better-quality care. To deliver this, we recommend the creation of integrated health and care commissioners at a regional level (with a statutory footing) to lead system reform. This should go alongside the creation of Integrated Care Trusts (ICTs) at the local level to join-up primary, community and social care. Modelling for this research shows that delivering this could save the NHS £4.5 billion per year by 2030 as a result of scrapping NHS Continuing Care as well as by reducing admissions to hospital and delayed transfers of care, as well as by shifting care into the community.

INTRODUCTION

Adult social care is one the most important public services in the UK. For hundreds of thousands of people it provides vital care and support – in their homes or in a residential setting – to ensure that they can maintain their independence, dignity and quality of life as they age. This may involve receiving help with basic tasks such as getting up or eating, or 24-hour support for people with complex needs such as dementia.

But unlike its sibling service – the NHS – social care has been consistently undervalued. This can be seen in the different principles which underpin the two services: whilst the NHS is free at the point of need, social care is means tested, with only those on low incomes entitled to receive statutory support. As a result, approximately half of all people formally receiving social care, privately finance at least part of their care – and this figure has been growing (Charlesworth and Johnson 2018).

This lack of 'parity of esteem' between the NHS and social care can also be seen in the relative funding settlements received over the last decade. Whilst the NHS budget has been protected in real terms since 2010, social care has faced significant cuts in spending. For example, between 2009/10 and 2016/17, spending on social care fell by 9.9 per cent (or 1.5 per cent a year), compared to a 10.3 per cent increase on public spending on health (ibid).

Unsurprisingly, these cuts have precipitated a crisis within the sector. This has manifested in four key trends.

1. **Rising unmet need.** Since 2008/09 there has been a staggering 5 per cent drop in the number of people receiving publicly funded social care per year totalling around 600,000 people (Darzi 2018). This has occurred despite a significant increase in the number of elderly people in need of care. This has left more people self-funding care, more people reliant on informal care for support and more people going without. There are 1.4 million people aged 65+ who face unmet social care needs, over double the number in 2010 (Age UK 2018. Moreover, the gap between need and provision is greatest for those on lowest incomes (Health Foundation 2017).
2. **Strains on quality and safety.** Quality across most dimensions of social care appears to have held up surprisingly well (CQC 2017). But, in too many places this is from a low base: more than one in five care providers – looking after over 200,000 people – are currently failing to meet the CQC's quality and safety standards. This grows to one in three when we consider nursing homes (ibid). Moreover, there is now evidence that social care is at a 'tipping point' where the drivers of improvement will come up short against the pressures on the system (ibid).
3. **Increasingly precarious provision.** Another concerning trend is the growing number of social care providers in the sector in debt or at risk of closure. Two-thirds of councils report that they have had a care provider that has closed, ceased trading or 'handed back' contracts in their area within the last six months (ADASS 2018). This problem has occurred because local authorities have responded to the cuts in their own budgets by reducing the fee paid to social care providers. This has led to a growing gap between the cost of delivering care and the rate paid by the local authority (UKCHA, 2016).

4. **Growing workforce pressures.** The impact of the cuts to social care are felt particularly strongly amongst the workforce. Nearly half the staff in the sector are paid below the living wage – with large numbers also paid below the minimum wage (Dromey and Hochlaf 2018). Partly as a result of this staff retention is poor and turnover is high, with around a third of the workforce leaving in any one year. This is leading to significant unfilled staffing gaps, due to grow from 78,000 today to 350,000 by 2028 – or 400,000 if freedom of movement comes to an end (ibid). This is important because the evidence is clear that the workforce is a key determinant of safety and quality (ibid).

There are also wider systematic challenges facing social care. Notably, since 1948, a boundary has existed between the NHS and social care. This boundary has given rise to four key fragmentations in entitlements, funding, commissioning and provision (Barker 2014). Unsurprisingly, this has contributed to fragmented and uncoordinated care, which is particularly problematic as people get older and require both regular health and social support. This fragmentation is increasingly failing to meet their health and social care needs.

There have been numerous attempts to overcome these fragmentations – and to achieve a long-term funding settlement for social care – but progress has been limited. The reasons for this are many and complex but include a lack of public understanding about what social care is and how it is funded; a low paid and low skilled workforce with limited voice or political power; and old and frail recipients who are often unable or unwilling to intervene in the debate (Pearce 2017).

However, we now have another opportunity to resolve this problem. In the 2017 general election Theresa May made social care one of her main priorities. While her initial solution – raising the threshold for state support of social care to £100,000 and including people's property in this means test (with a cap on costs only included following a public outcry) – was ultimately abandoned, her government have committed to delivering a green paper on the topic followed by concrete actions to deliver lasting change.

Now, more than ever, it is crucial that the government 'grasps the nettle'. The UK's population is set to age significantly over the next decade with the number of people over 65 set to increase by 33 per cent – compared to a mere 2 per cent increase in the number of working age adults – while the number of over 85s will nearly double over the same time period (Darzi 2018). This will see demand for social care grow at an even faster rate than for the NHS (Wittenberg et al 2018). Failure to do so will not only result in meeting less need for older people, but increasing high-costs of care and greater inefficiencies in the NHS.

This paper looks to set out what a bold and comprehensive reform package would look like – building on the recent proposals set out as part of IPPR's Lord Darzi Review – in the run up to this government intervention (Darzi 2018). This proposal can be set out in three simple steps.

- **Step 1:** Introduce free personal and nursing care in England.
- **Step 2:** Fully fund free personal care from the same source as the NHS.
- **Step 3:** Join up health and social care commissioning and provision.

STEP 1: INTRODUCE FREE PERSONAL CARE

The concept of free personal and nursing care derives from the Royal Commission on Long Term Care for the Elderly which reported in 1999 (Sutherland 1999). This commission recommended that care - whether it is delivered in the NHS, a care home or in someone's house - should be free at the point of need. This would create a more coherent system ensuring parity between people with cancer, who currently receive all their care free from the NHS, and dementia patients, who have to pay for theirs in the social care system.

The commission distinguished these care costs from the other costs faced by individuals, notably accommodation (or hotel) costs. These would still need to be funded by the individual unless they meet the means test set by the state (eg have low levels of income or wealth). The logic behind this division between care and accommodation costs was to create a level playing field between residential and home-based care (eg accommodation costs are not state-funded when someone receives care in their own home so nor should they be when someone receives care in a residential home).

This change, in effect, redraws the boundary of the NHS – or at least extends the principles underpinning it - to include elements of social care. The justification for this change rests on the similarities between care in the NHS and in social care. It also recognises the interdependency of both systems: only by removing the divide in entitlements between health and social care can you really join up health and social care provision and shift care into the community in order to improve outcomes and efficiency (these benefits are discussed in more depth in the following chapters).

DEFINING PERSONAL AND NURSING CARE

Personal care includes personal hygiene tasks (shaving, cleaning teeth), eating requirements (food preparation), mobility assistance, medical treatments (administering creams and medications), and attending to general wellbeing (dressing, getting in and out of bed). It does not usually include household tasks such as shopping and cleaning.

Nursing care includes any care involving the knowledge or skills of a qualified nurse. In England this is currently provided through the NHS (either as part of community care or NHS continuing healthcare) or is funded and delivered privately. Nursing care may include pain control, managing medications, intravenous therapy and wound and pressure management.

Whilst the government in England rejected the recommendations made by the Royal Commission on Long Term Care for the Elderly, largely based on cost, Scotland decided to implement them. This allows us to understand how this system might work in practise. Under Scotland's model those over 65[1] who meet a certain needs threshold

1 Scotland is currently pursuing reform to extend free personal care to under 65s.

receive nursing care and personal care free-at-the point of need. In practise, this means different things for those in a care home to those in their own home.

- For people living in a care home the local authority pays a flat rate of £174 per week directly to a care provider (Scottish Government 2018). If they are also assessed as needing nursing care, the local authority pays an additional £79 per week (ibid).
- Those who receive care at home are not charged for any personal care services (ibid).

Free personal care in Scotland also interacts with the benefits system, in particular attendance allowance (AA) (and disability living allowance).[2] AA 'provides a financial contribution towards the generality of extra costs experienced by disabled people as a direct result of their disabilities'. The majority of those receiving AA – around two-thirds – are older people (above the age of 80). In Scotland those who receive free personal care in their own home can still claim AA but those who are in a care home are ineligible.

LESSONS FROM SCOTLAND

We now have over a decade of evidence on the design, implementation and results of free personal care in Scotland. Based on interviews with health and social care leaders in Scotland and an extensive literature review we believe there are a number of conclusions that can be drawn to inform the design and implementation of free personal care in England:

Properly define personal care

When free personal care was introduced in Scotland there was no precise definition in the legislation of what this service included and what it did not (and would therefore need to be funded by the individual unless they met the means test set by the state) (Audit Scotland 2008). Food preparation and shopping were particularly controversial with some areas providing them free at the point of need and others charging users for them. This resulted in extended debates between service users, local authorities and the national government (including a number of legal challenges) which has resulted in them being excluded from the definition (ibid).

Focus on quality as well as quantity

Free personal care in Scotland was not introduced alongside a clear framework setting out what they were wanting it to achieve (eg better access, better outcomes, greater efficiency etc) (ibid). Whilst there is significant evidence of increased uptake of social care both in terms of numbers of people and hours of support, there is very limited evidence on the quality of care or its impact on efficiency (Bell and Bowes 2011). This is made more difficult to correct as a result of limited data collection.

Fully fund free personal care

There is significant evidence suggesting that free personal care in Scotland has not been fully funded by the government. For example, the auditor general in Scotland has estimated that there has been a funding gap of up to 10 per cent of the costs of the policy with this figure growing over time (Audit Scotland 2008). This has resulted in rationing in the form of growing waiting times for care in Scotland and (unofficially) a higher needs test being applied in some areas. It has also led to the tariff paid to providers for free personal care growing more slowly than the cost of providing care,

2 Attendance Allowance is closely linked to Disability Living Allowance because the latter currently performs the same function for those under the age of 65.

with providers increasing the cost of other services (privately funded) to compensate for this.

Deliver free personal care alongside a wider reform agenda

The evidence from Scotland is clear that many of the benefits of free personal care in terms of the quality and efficiency of care can only be obtained if it is combined with other reforms on the ground (Bell and Bowes 2011). In Scotland, free personal care was introduced alongside other changes aimed at 'shifting the balance of care' from the hospital to the community including joint health and care commissioning, the integration of provision and more preventative health and social care to keep people out of hospital (ibid). Those areas that have gone furthest and fastest have delivered significantly better outcomes than others – and variation across the country is significant.

Crowd-in rather than crowd-out carers

Ahead of its introduction in Scotland many argued that free personal care would simply crowd-out informal care from family and friends. However, the evidence does not support this: there has been no reduction in informal care hours delivered in Scotland (Bell and Bowes 2011). Instead there is evidence that carers switched the tasks they perform from basic caring functions (eg washing or dressing) to emotional and social support (with greater flexibility about when this care was delivered). This is a particularly striking finding given that the evidence suggests that social and emotional support is the area of care in England that has suffered the most under austerity (Darzi 2018). This suggests that the introduction of free personal care could address this deficiency and significantly improve the quality of care in England.

CATASTROPHIC CARE COSTS

New evidence from Independent Age shows that free personal care could almost halve the number of people experiencing catastrophic care costs over £100,000. However, it does not eliminate the problem entirely as many people will still need to pay for residential care: up to 80,000 people (nearly 1 in 5 people in residential care) will still face catastrophic care costs (Independent Age 2019).

There are a number of potential responses to this problem which IPPR will investigate in more detail in future work.

Do nothing

At present, a means-tested system is in place to determine how much support an individual is entitled to, should they require residential care. Those with assets over £23,250 are expected to fund their own care. The local council will pay for the care of anyone with less than £14,250. Partial funding is available to anyone between these two amounts. Housing assets are taken into consideration, providing there are no dependants still living in the house.

This system has a number of strengths. Notably, it is progressive, in that subsidised care is focussed on those with limited resources, and those who do pay have some protection (though the residual remains very small eg £14,000). However, the low upper-threshold means catastrophic costs can be substantial for those who do pay. As set out already, up to 80,000 will still have to pay over £100,000 for their care, and around 16,000 of these

are at risk of this consuming over half of their wealth (their wealth is worth £200,000 or less) (ibid). This represents a heavy financial burden which may require people to sell their home and forgo leaving an inheritance to their children.

A cap on care costs

One policy put forward to address this challenge is a cap on lifetime care costs as recommended by the Dilnot commission (ibid). Under this system, individuals would not have to pay for their care once they have reached a specified threshold. The present means-tested system would remain, but those ineligible to receive state support would only pay until they reached the cap.

It has been argued that the cap would provide clarity, so individuals understand exactly what they are expected to pay and plan accordingly. It also offers more protection to homeowners if they should need care. However, it also adds an additional layer of complexity to funding. Meanwhile, a cap is also of greater benefit to those with more assets - it is essentially regressive (Barnfield et al 2017). It would also be costly: we estimate that a cap of £85,000 would cost around £3.2 billion.

A less regressive option would be a cap on care costs for only those people at risk of losing half of their wealth (people with wealth of £200,000 or less). This would protect those most at risk from catastrophic care costs but without subsidising people with much higher levels of wealth. We estimate that the maximum cost of such a cap (set at £85,000) would be around £350 million.

A more generous means-test

Another, more progressive approach, would be to raise the means-test threshold so that an individual would only begin self-funding at a higher level of income or wealth. It has been recommended that a floor for means-testing should be set at £100,000 (up from £14,000) (Wenzel et al 2017). A higher threshold would offer greater protection for those with few assets and increase the liability protection for those who do pay, as they will cease paying for care once their assets have fallen to the new, higher floor.

This would offer a substantial proportion of the older population protection from the risk of catastrophic care costs. Only those with the highest incomes or levels of wealth would face catastrophic care costs and the more generous means test would ensure that they would under all circumstances be able to retain a sizeable portion of their assets. However, it remains to be seen whether this approach would be politically acceptable to the general public.

POLICY RECOMMENDATIONS

The division that has existed between health and care in England since 1948 has been retained for far too long. It is time for change. As individuals we make no distinction between health or social care needs: neither should our public services. We therefore recommend that England builds on the Scottish model – correcting for some of the lessons learned north of the border – by introducing universal, free-at-the-point-of-need personal and nursing care for adults in England. There is a growing number of health and social care leaders and organisations mirroring this call (eg The King's Fund Barker Commission and Independent Age charity).

- **The government should implement free personal care for over 65s in England**. This must be introduced alongside a clear definition of what is included in the free personal care offering and a clear quality framework setting out what the government is aiming for the policy to achieve. The government should also consider introducing free personal care for those under 65 as is happening in Scotland.
- **Accommodation costs should continue to be means tested.** But the government should reassess whether the current means test is set at the appropriate level and whether a cap is needed (though IPPR believes if a cap is introduced it should only benefit those with lower levels of wealth, for example below £200,000).
- **Free personal care should initially be made available only to those with the highest needs.** Free personal care should initially only be available for those with critical or substantial needs.[3] Over time this should be extended to those with lower levels of need, making it a universal entitlement. This would ultimately see the number of people receiving state funded social care more than double (from 185,000 in 2019 to 440,000 if it was delivered today and full take-up was achieved). This would radically reduce unmet need and pressure on informal carers.
- **Attendance allowance should be re-purposed as a care allowance for people with lower levels of need.** Attendance allowance should be brought into the social care system and offered to people with lower levels of need. It should act like a personal budget and have the specific aim of maintaining people's independence.

3 We define this as being unable to perform at least seven out of a possible 15 activities of daily living (ADLs)

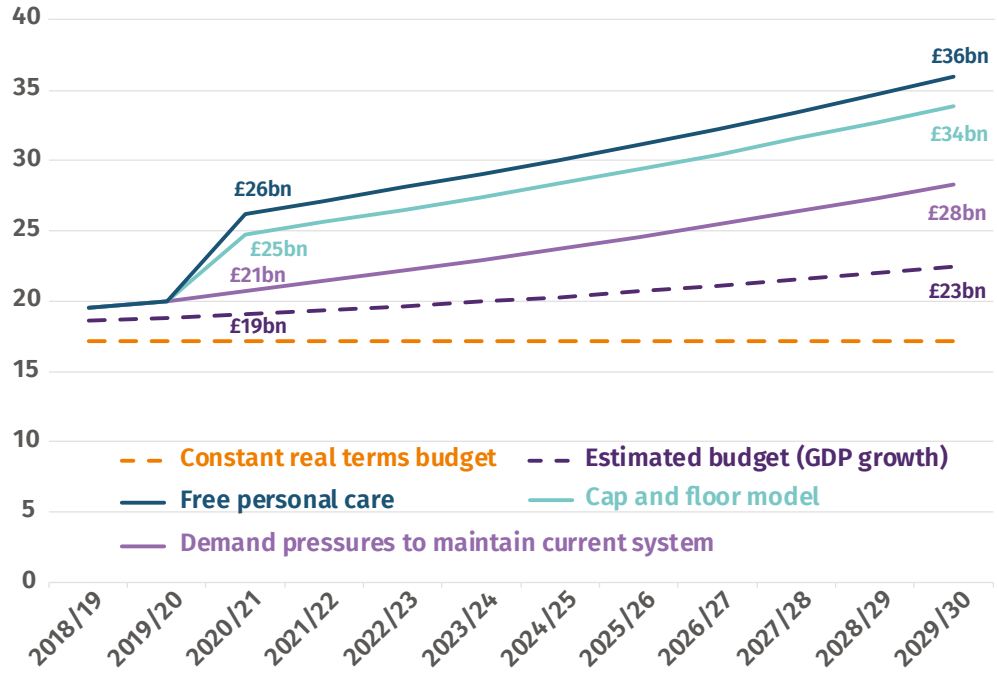
STEP 2:
FULLY FUND SOCIAL CARE

Delivering free personal care is only slightly more costly than the government's cap and floor proposals at the time of the general election. Recent estimates of cost by the Health Foundation show that just to meet the demand pressures on the existing system spending will have to increase from around £17 billion today to £28 billion in 2030 (an additional £11 billion) (Bottery et al 2018). Free personal care would see this increase further over the same period from £17 billion today to £36 billion in 2030 (an additional £19 billion) (ibid). This figure would increase further if the government also decided to introduce a cap or a more generous means test.

This may seem unaffordable but in reality it is only marginally more expensive (£2 billion per annum by 2030) than the policy proposed by the Conservative party at the last election. Likewise, the additional cost is small relative to what we spend on the NHS and across government as a whole. Our calculations suggest that the additional cost in the first full year of implementation would be equivalent to about 6.9 per cent of total NHS spend and around 1 per cent of total government expenditure. However, the actual cost is likely to be lower as this does not include the other savings which might be delivered by free personal care and great system integration (see below).

FIGURE 1

Projected social care funding gap (£bn) under various policy changes



Source: Bottery et al (2018), IPPR calculations

However, these cost increases could be offset further by the potential efficiency savings delivered by greater integration between health and social care. Some of these can be achieved as an inherent part of the system re-design. For example, the introduction of free personal care should make NHS continuing healthcare redundant which IPPR calculated could deliver an annual saving of up to £2 billion per annum rising to £3.3 billion by 2031 (see info box).[4] There could be savings on attendance allowance (if it only becomes accessible to people in their own home as in Scotland).

NHS CONTINUING HEALTHCARE

NHS continuing healthcare (CHC) is out-of-hospital care provided to adults (over 18) with significant ongoing health care needs. CHC, which can include health and social care, is arranged and funded solely by the NHS. While those assessed as eligible for CHC receive their care for free (including accommodation if in a home), those who do not meet the criteria receive social care on a means-tested basis and therefore may be required to pay some or all of the costs themselves.

CHC was introduced in recognition of the fact that for those with significant health needs (sometimes referred to as a primary health need) their care should be funded by the NHS. However, in these circumstances it is impossible to distinguish between someone's health and social care needs. In these cases, under CHC the NHS was given full responsibility for funding both. But under a new regime of free personal care this distinction would not need to be made: everyone would have access to the care they need free at the point of need regardless of whether it was medical or social.

Other savings can be delivered by changing the model of care across the NHS and social care to prevent people from needing acute care (eg A&E admissions) or to move into a care home, and by shifting the location of care to lower cost settings (eg end of life care). These changes require more investment in social care – and would benefit from free personal care – but also require a much more comprehensive set of reforms as set out in the next chapter.

WIDER BENEFITS TO THE ECONOMY

There are a range of wider benefits to the economy that further investment in social care and introducing free personal care would induce. Social care is a large and growing sector. Increased spending associated with personal care will generate additional demand, not just within the sector, but throughout the supply chain, creating a positive economic effect.

We estimate that the introduction of free personal care would mean a 2.5 per cent increase in demand for social care services. By 2030, a comprehensive service would require £3.4 billion to meet such demand. This would add £2.5 billion to UK gross value added (GVA) across every sector in 2030.

Based on our assumptions, free personal care would require just under 70,000 new full-time care workers to join the sector immmediately to meet the potential increase in demand. Through the additional consumption this would generate across the supply chains, we estimate that over 85,000 jobs could be created thanks to the introduction of free personal care. By 2030, free personal care would mean 110,000 jobs in England.

4 This is based on a 70/30 split between those receiving NHS continuing healthcare in a home versus their own home and 75/25 split between accommodation costs and care costs.

These benefits do not negate the need to find a long-term sustainable solution to social care funding. The current system is unsustainable. Social care is funded by local authorities from a mixture of sources including central government grants (though this is declining[5]), the Better Care Fund[6] and local taxes including business rates and council tax. This is problematic for a number of reasons.

- The tax base is not deep enough in most local areas to deliver significant increases in funding. For example, Independent Age find that local authorities would have to raise council tax or business rates by over 50 percentage points by 2030 to fund free personal care (Independent Age 2018a).
- There is no link between need and revenue raising potential across the country which leads to inequitable provision of care. For example, the IFS find that one in five councils have seen their relative ability to raise local tax revenues fall, whilst their relative need for adult social care increased (Amin-Smith et al 2018).
- Local taxes, in particular council tax, are more regressive than many comparable national taxes. For example, under the current council tax regime those living in homes worth £100,000 pay on average around five times the tax rate of those living in £1 million properties (Gardiner 2018).

The only logical solution going forward is to fund the NHS and social care from the same source: general taxation collected at the national level. The most commonly cited solution is some form of wealth tax, recognising that older people tend to have higher levels of housing wealth. For example, in 2010 Andy Burnham proposed a one-off lump sum payment at the age of retirement to fund social care which could be deferred until death to prevent people needing to sell their property (DoH 2010).

However, as we have argued previously in the Lord Darzi Review, this poses a significant challenge. Taxing wealth is a politically vexing issue. It is universally unpopular and virtually no country in the world has yet managed to resolve it satisfactorily, with even the best performing country only bringing in 3 per cent of GDP in property and wealth taxes per year (Lawton and Reed 2013). If we make reforming social care contingent on increasing wealth taxation, we are locking in the status quo. We must not let this happen.

This leaves two obvious candidates to fund social care going forward: income tax and national insurance. Both are broad and deep enough to raise significant sums of money. For example, recent analysis from Independent Age finds that to fully fund free personal care, national insurance (both the employers and employees rate) would have to increase by 1.31 percentage points or income tax by 2.11 percentage points respectively (Independent Age 2018a).

Both are also reasonably popular (unlike wealth tax increases). For example, polling conducted by YouGov for Independent Age found that almost three-quarters (74 per cent) of adults in England support free personal care for everyone who needs it, with more than two-thirds of adults in England (69 per cent) agreeing that they would be willing to pay more tax to provide free personal care for all. The two most popular methods of raising these funds were income tax and national insurance respectively (Independent Age 2018b).

5 Under the government current policy local authorities will raise an increasing share of their income from locally raised taxes (through business rate retention and other forms of fiscal devolution).

6 A joint NHS and local government fund aimed at joining up health and social care

POLICY RECOMMENDATIONS

Social care has been undervalued and underfunded for too long. We need a long-term funding solution that ensures everyone has access to the care they need, and which enables integration with the NHS. We argue that going forward free-personal care should be funded from the same source as the NHS: general taxation collected at the national level.

- **The government should fully fund free personal care from general taxation collected at the national level.** This could be derived from an increase in income tax or from national insurance as recommended by the Lord Darzi Review and aligned with the right to free personal care. The latter may benefit from reform to include over 65s in the tax base and to make it more progressive.
- **The government should offset some of the additional cost of this policy by reforming NHS continuing healthcare.** NHS continuing healthcare should be scrapped with all people receiving care in the community subject to a means test for accommodation. This could save up to £2-3.3 billion per year. This would fund the implementation of this policy based on costs and demand today.
- **The government should introduce this policy with an explicit objective to drive efficiency savings in the NHS.** This would focus on reducing delayed transfers of care, reducing admissions to care homes and hospitals and shifting end of life care out of the hospital.

STEP 3:
JOIN UP HEALTH AND SOCIAL CARE

Introducing – and fully funding – free personal care are the first crucial steps on the road to a better health and social care offer for older people. But whilst ending the fragmentation in entitlements and in funding between the NHS and social care is necessary in order to deliver high quality and joined up care, is not sufficient on its own. For this, we need to ensure that the introduction of fully funded free personal care is combined with fundamental reform in the way care is actually delivered on the ground.

HIGHER QUALITY CARE

There is a growing consensus about what best practise health and care looks like for older people. This highlights four key characteristics, each associated with new emerging models of care.

Preventative care

This means intervening earlier to maintain people's independence in their own home or a care home for longer. Best practise examples of this include helping people to plan and self-manage frailty before they are admitted to hospital or a care home; integration of the NHS and care homes through training of social care staff and telehealth and telecare to keep people out of hospital; and high quality reablement services to reintegrate people into their home and community having been admitted to hospital (Holder et al 2018).

Joined-up care

This means creating a package of care around the whole person rather than addressing individual needs separately. Older people want a single point of contact across health and social care to coordinate their care, with expertise provided from a wider team of professionals only when it is needed. Best practise examples include the replacement of multiple professionals with a nurse to cover all (or most) care needs (eg the Buurtzorg model) and the integration of district nursing, allied health professionals and social care support (and sometimes the acute provider, primary care and mental health) into a single team (Gray et al 2015).

Accessible care

This means delivering care at the right time and in the right place. This is partly about reversing the rationing of social care which has taken place over the last decade. But it's also about changing where and how care is delivered. Best practise examples include a much greater focus delivering low intensity support early on in people's homes, communities or care homes (rather than waiting for crisis point to intervene), as well as shifting care out into the community at the last stages of life as well (eg end of life care) (Georghiou and Bardsley 2014).

Personalised care

This means tailoring care to needs of the individual. It's about giving patients choice over what care they receive and where they receive it. It requires health and care staff to work with each patient – treating them as an individual – to co-produce a care plan which speaks to their needs and wants. It means ensuring care is never transactional, always relational. Best practise examples of this include giving older people on named care coordinator, the introduction of care planning at an early stage to give people choice and help them self-manage, as well as the use of personal budgets covering not just social care but health as well (House of Commons 2016).

Many of these changes to the care model can be delivered within the constraints of the health and care system as it stands (eg through better communication, informal partnership, federations etc). However, there is also a growing recognition that shifting the model of care (as described above) benefits from – and in some cases requires – a change in the system architecture (Darzi 2018). At the provider level, this means bringing together all local primary, community, mental health and social care provision (and potentially some element of acute care) into one organisation.

The Lord Darzi Review (ibid) called for this to happen in the form of new organisations: Integrated Care Trusts (ICTs). Indeed, some areas have already started to do this through the creation of primary and acute care systems (PACS) and multi-speciality community providers (MCPs) as part of the Five Year Forward View (NHS 2017). This change makes it easier for providers to redesign care pathways, re-think the workforce to create integrated teams and deliver more holistic care.

FRAGMENTED SOCIAL CARE PROVISION

In recent years, there has been a progressive shift away from social care being provided by the state and a growth of outsourcing to independent providers. These include private, for-profit providers and charities. In 1979, 64 per cent of residential and nursing home beds were still provided by local authorities or the NHS. By 2012 this had fallen to just 6 per cent. In homecare, the change has been quicker still: in 1993, 95 per cent of homecare was provided by local authorities; by 2012 this had fallen to just 11 per cent (Hudson 2018).

This has led to a significant fragmentation in provision. There are now over 10,000 care homes with over 5,000 providers, whilst there are over 10,000 regulated providers of home care. Whilst there is little doubt that the independent sector can add value to social care provision, there is also growing evidence that private providers are more likely to underpay staff or face staffing gaps, which we know is linked to poorer quality care (Dromey and Hochlaf 2018). Just as important in the longer term is that outsourcing in this way creates greater provider fragmentation across health and care and makes delivering integrated care more challenging.

Over the longer-term commissioners may want to consider packaging up social care tenders in different ways in order to enable the care models set out in this chapter. For example, over the longer term, provision of the 'care element' of social care may benefit from being provided by the state as part of the new Integrated Care Trusts(ICTs), with the provision of care homes and personal care tasks not included in state provision (eg cleaning, shopping etc) provided by the private and voluntary sectors. This may well enable changes such as the consolidation of the workforce to drive greater efficiency and continuity of care (eg Buurtzorg nursing care).

This must be delivered alongside a 'new deal' for primary and community care in terms of funding. Historically, primary and community care funding has consistently grown more slowly than acute funding. Policymakers have rarely met their promises to properly resource the primary and community sector (Baird 2017). For example, the majority of transformation funding provided for the FYFV appears to have been redirected into reducing provider deficits (NAO 2018). Matt Hancock, the health secretary, has committed to ensuring that community and primary care funding increases year on year. This pledge must be kept.

However, funding is not the only change that is needed to enable integrated provision on the ground. Delivering integrated provision without integrated commissioning is challenging. Since the 2012 Health and Social Care Act commissioning for acute and community care has been undertaken by Clinical Commissioning Groups (CCGs) (at a more local and smaller scale than before), primary and specialised care by NHS England and social care and public health by local authorities. This has created an excessively complex and fragmented landscape.

In looking to overcome this policy makers have had to resort to workarounds because this fragmentation is 'locked in' by primary legislation. This has led to 44 'sustainability and transformation plans' (STPs) – now evolving into integrated care systems - which bring together all of these commissioners at the regional level to coordinate commissioning and drive transformation. However, they are struggling as they have no legal basis, unclear governance, and no authority for decision making (Darzi 2018).

Genuine progress on this front – for example in Greater Manchester where health and care commissioning has been integrated across the region – therefore remains the exception rather than the norm. This is why the Lord Darzi Review called for all CCGs to be abolished, the 44 STPs to be given a proper legislative framework (to perform a local commissioning function) and the creation of five to ten regional strategic commissioners to drive transformational change, with both new sets of organisations governed jointly by local health and local government leaders (ibid).

POTENTIAL EFFICIENCY SAVINGS

These changes are primarily aimed at delivering better quality care for vulnerable older people. However, it is also possible that these changes also lead to efficiency savings for the NHS. Three channels can be identified through which this might happen.

Lower admissions to hospital

Evidence suggests that every additional £100 spent on social care will reduce A&E costs by £3 per head (Crawford et al 2018). Our estimates suggest, given the overall increased expenditure on free personal care, this would generate savings worth £270 million per annum and a cumulative saving of £3.3 billion by 2030. In addition, the reduced demand for A&E services would help ease the pressures on emergency departments and allow staff to focus their efforts elsewhere.

End of life care

At present 47 per cent of people in England die in hospital, while only 23 per cent die at home. The measures set out above could help tip the balance towards death at home. If we matched the best performer in western and northern Europe in terms of end of life care – the Netherlands – where only 31 per cent die in hospitals and 37 per cent die at home (Hunter and Orlovic, 2018), then this could generate an annual saving of at least £267 million and cumulative saving of £3.5 billion by 2030 (if the acute beds were closed as a result).

Delayed transfers of care

In 2017, a high volume of delayed transfer of care (DTOC) cases cost the NHS just over £173 million per year (Bate 2017). However, Carnall Farrar have estimated that the true cost of delayed discharges is actually closer to £3 billion per year (Andrews et al 2017). This is partly due to many being medically fit for discharge but omitted from the DTOC data. Carnall Farrar also estimate higher bed-day costs. If greater investment in social care helped to reduce DTOC to 2010 levels, then this could generate a cost-saving of £70 million a year for the NHS according to official estimates, and as much as £670 million using Carnall Farrar estimates.

POLICY RECOMMENDATIONS

Ending the fragmentation in entitlements and in funding between the NHS and social care is necessary in order to deliver high quality and joined up care it not sufficient on its own. Free personal care must be introduced alongside a wider reform agenda designed to integrate health and social care commissioning and provision, as well as shift the model of care to be more preventative, joined-up, accessible and personalised.

- **Free personal care must be introduced alongside integrated commissioning across health and social care.** The 44 STPs should to be given a proper legislative framework to perform a local commissioning function. In addition, five to 10 regional health and care authorities (HCAs) should be created as strategic commissioners. Both STPs and HCAs should be jointly governed by local health and local government leaders.
- **Provision should also be integrated in the form of new Integrated Care Trusts (ICTs).** ICTs – which could build on existing new models of care – should bring together primary, community, mental health and social care provision (and potentially some element of acute care) into one organisation. This may also involve the care element of social care provision over time.

ANNEX

TECHNICAL NOTE

To estimate the potential economic gains, we started by using data from Wave 7 of the English Longitudinal Study of Ageing (ELSA) to estimate the proportion of adults over 65 who had reported difficulties with activities of daily living (ADLs) but received no professional help from a social care worker. We assume that everyone who reported more than seven difficulties would be eligible for free personal care. We hold this proportion constant to estimate the future increase in demand.

Assuming a weekly spend of £210 for domiciliary care services, we project the total value of the additional increase in demand generated by free personal care. We then used the turnover to GVA ratio (0.51) to estimate the direct GVA gain from this additional spending (Kearney and White 2018). Using the social care multiplier found in the latest UK Input-Output tables, we estimate the total direct and indirect GVA gain from additional spending.

To estimate the employment effects, we assume that each care recipient would on average receive 10 hours of care a week. From this we estimated the total number of full-time equivalent jobs this would require. We then applied the employment multiplier from the UK Input-Output tables to calculate the total number of jobs additional investment would generate (ONS 2018).

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