

## **Fixing the State of Social Care**

### ***How bad is the crisis?***

It's really bad. The Government's own monitor, the National Audit Office, has described the current approach as "fail and fund."

There have been 14 major reports promising national solutions since the Sutherland report of 1999 [Royal Commission]. Virtually nothing changed. Social care remained the "and" which always gets added on to health policy. It is of course now recognized in the title of the Government department – DHSC, but despite the equivalence of letter size there is none in reality.

The second fiddle status comes from a mix of cultural as well economic, social, political and professional traditions. Perhaps one of the simplest factors is that a minority of people – 26% is the highest estimate I've found – receive adult social care in their lifetime, whereas everyone in some way becomes a NHS patient. Yet we will all know someone, mostly a family member, who does get adult social care. Informal care is hugely under-valued and under-represented in policy formulation. [Over 6 million people, part or full time carers for a family member, and 1 in 9 employees]. Sue Himmelweit and the Womens Budget Group have documented just how much unstated or unrecognized womens work subsidises the economy. At the same time surveys have shown a majority of people to believe that social care is freely provided, while in fact it is mostly means tested and for residential care can mean a person having to relinquish their home.

Since 2010 about £7 billion has been taken out of social care and around half a million people in need have lost a vital service such as meals on wheels. Poorer urban locations have lost most. Haringey borough has lost 17 day centres

since 2010. Local Authorities, sometimes with cuts of 40% in their budgets in that time have cut grants severely and leave vacancies unfilled just to make ends meet.

So assessments don't get done, or folk in dire need join a long queue – waiting time – while their conditions get worse or they end up more frail and isolated and then costing the NHS more or having to go into residential care. Eligibility criteria get ever tighter, so that you have to be very high need to get direct intervention while at the same time all the rhetoric and policy intention of health and local authorities working more closely together is for supporting people at home and catching those at risk earlier. The rhetoric and reality are poles apart.

### ***What are the needs, and the prospects ?***

There will be a projected doubling of over-85s in 15 years time. Half a million more people will need 24 hour continuous care than do now [IFS/HF]. Co-morbidity is likely to rise by 8% per year – i.e that many more people living with complex conditions – while by gender, there is a positive compression of morbidity years for men over 65 [more 'living well' years] but for women an expansion of morbidities. This trend may in part counter the long term one where many more women than men live into the late 80s and 90s. [data from Knapp, PSSRU, and Inst. For Ageing, Newcastle U.] The Government's "Grand Challenge for Healthy Ageing" with an extra 5 years of healthy living compared with now, even if it succeeds, will also mean some more time less healthy, as most of us will not be lucky enough to die just as those healthy years come to completion.

Adult social care is for different kinds of people, the bulk in numbers being elderly, but more than half of local authorities spend a larger proportion of their budget on people with learning disabilities. People with physical and

sensory disabilities are a minority in numbers, but also particularly, and adversely, affected by social security cuts and changes, and those with mental health issues often the least well served of all. Dementia diagnoses are increasing apace, just as depression and isolation are becoming more recognized as major challenges to wellbeing for older people. And many more people with learning disabilities are projected to live longer and require continuous care beyond the lives of their parents. At the same time as there is growing need for continuous care of dependent people, the voice of users and carers rightly demands full participation in determining the process and outcomes for social care. This complexity of rights and needs is poorly served by the market and the current fragmentation of social care 'offers'.

### Workforce.

The total workforce for health and social care in England is about 10% of those employed, but by 2033 is estimated to rise to 14% - and this at a time when automation is threatening to both downsize and de-skill so many in work. Unison estimate another 650,000 jobs in social care in that time just to keep pace with rising need.

The Audit Office say what is required is a national workforce strategy for social care and a proper 10 year plan for ASC in lockstep with that for the NHS.

Currently there is a 30% turnover of adult social care staff in a year [DHCLG, 2018], an unsustainable amount for continuity of relationships which is the most significant factor in quality of care.

Clearly a national system of qualification for care workers and a viable career structure are long overdue, along with a decent wage structure. The lack of value attributed to staff, especially those engaged in direct personal care, is most probably the biggest obstacle to overcome in transforming adult social care. Real investment in regulation is vital.

## The Green Paper?

News from inside DHSC is that there will be 3 particular things in the Green Paper –

- \* A roll out of Enhanced Health Care in Care Homes which means making sure local primary health care networks and a person's GP are extended to 24/7 premises;
- \* Extending Personal Budgets more into health care;
- \* Roll out of Local Health and Care Plans, and in the next 5 years for individuals gaining better access to their records and improved experience of the system.

They are looking to 'stabilise the market' [whether or not this would mean ending compulsory competitive tendering not said]. And significantly the funding resolution – what do about the Dilnot or 'cap and floor' formula for funding residential care – is likely to be left to the Spending Review towards the end of the year [E.Moses, DHSC].

Others such as Niall Dickson [Health Confed.] call for a review of the restricted eligibility criteria as well as a proper workforce strategy, and reform to the Carers Support Allowance with more explicit support for unpaid and informal carers. He and other insiders are now calling for a **new public discourse** and a new **social contract between the public and the social care** sector. 2019 has to be the year in which social care is fixed.

Public health is now a local authority responsibility but much under-invested. Raising the population wellbeing agenda, with adequate funding, needs to come in advance of any structural integration of health and social care, for the status and quality of social care to be given its rightful place.

## ***What needs to be done?***

We need a national public discourse and a move towards equivalence of social with health care, and all that implies.

**1] The recognition of national rights to care** until the end of life [as with health] ending the unfair and costly anomalies such as a person with dementia often having to pay for their care while with cancer they would not. This would require a new Act whether a Social Care Act or as part of a new NHS and Social Care Act. If a NHS Reinstatement Bill gets taken up as it stands then a new SC Bill would have to be put forward, unless they are put forward as an amalgamated Bill. The logic for amalgamation in legislation is strong given that health and wellbeing are now widely recognized [e.g.WHO] as inextricable from their social dimensions. At the same time it will be important not to undermine the democratic accountability of local authorities, and reconcile this with NHS structure which has no such real local accountability, and even the accountability of the Secretary of State was reduced by the 2012 NHS Act. The principles which most apply to the social elements of care are universality – available to all – and subsidiarity – at as local a level as possible. The Reclaim Social Care model resolution for Labour Parties sets this out.

## ***2] Adequate funding***

Funding boils down to either taxes or private money however raised. This can be disaggregated as follows:

- \* Regular income tax or national insurance;
- \* Council Tax or Business Rates;
- \* Inheritance Tax;
- \* A new form of tax [one proposal – National Pensioners Convention [NPC] –is to levy a contribution from those over 40 years of age as a NI supplement;
- \* Private sources such as Equity Release, or long term subscribed insurance policies

There are drawbacks, fairness issues and political challenges with each [summarised in January 2018 Westminster Care seminar] except regular tax and national insurance.

Interestingly the Citizens Assembly programme tackling this issue over the previous six months came out with the biggest consensus for universalizing social care through taxation, i.e. that “it should be paid for through public funding and free at the point of delivery like the NHS”. Martin Knapp [PSSRU] found that people preferred a mix of general and earmarked taxes, and/or a national insurance supplement starting in middle age but rejected VAT, Inheritance and Council taxes.

The Dilnot Commission advanced the ‘cap and floor’, going from the current £23,000 floor to £75,000 beyond which people would be self-funding for residential care. This was held over by the Government until the forthcoming Green Paper but that may not come up with a full solution and will probably prefer to link funding to their long term spending review. Fail and fund, or cap and fund. Neither offers a fair way forward, as with almost any threshold chosen for ‘cap and floor’, there is a transfer of wealth away from the poorer population to those better off. [This is exemplified elsewhere – NPC, Kings Fund/HF and in short paper from Ann Bannister].

Overall, if the Dilnot proposals for cap and floor were implemented it would cost £5.2 Billion now, and £12 Billion by 2031 [Kings Fund and Health Foundation].

If free and universal care were implemented now through tax it would cost £7 Billion, and £14 Billion by 2031.

There is not then a huge difference in going for the fairer universal tax-funded care. And as it happens the £7 Billion more or less equates to the amount of money taken out of the system by Government cuts since 2010.

***3] The recognition of adult social care [ASC] as a major economic contributor***

In most conventional discourse, and political as well, ASC, tends to be seen as a drain on resource even as it 'eats up' the largest portion of many Council budgets. It is not. In 2013 a report by City accountants, ICH/GFK, calculated that adult social care contributed two to three times in revenue to the economy of England more than it cost, through direct, indirect and induced expenditure mainly by the workforce employed. The West Midlands, supported by research from NEF, are basing their social care policy on the sector as an economic generator and linking it to housing, employment and apprenticeship, and Council-wide policies.

Kirklees and Sunderland have established mutualized approaches to public partnership provision of social care, emphasizing the benefits of good employment practice and co-ownership.

Valuing the workforce can only underline the economic and social benefit. The example of *Qulturum* in Sweden where the social care sector is part of a learning and improvement collaborative for the system opens out the same approach to the local authority, health, voluntary organisations and care homes, and is open to developing with full carer and user participation. *Buurtzorg* in The Netherlands lays emphasis on the recognition of the value of care work, particularly the emotional intelligence required of care workers. Sue Himmelweit in England with the Womens Budget Group surfaces the under- and un-recognized economic contribution of women in caring.

The full economic and social recognition of care work is then a vital task, and one that should be integrated in policy development for adult social care. A proper national system of qualification for carers and application of the Ethical Care Charter [Unison], along with real investment in regulation would be a good start.

#### **4/ Response to the forthcoming Green Paper**

The long awaited Green Paper will now most likely be at best a stopgap. The Local Government Association has made its demand for more investment, but not really anything on changing the nature of the policy debate towards real equity and equality for social with health care. There is probably now in 2019 a fairly narrow window of time, as Niall Dickson said at the Westminster Care seminar, in which to sort out adult social care and its longer term funding. It needs to be linked to housing and economic policy regeneration. Adult social care is going to be the biggest area of employment growth by far in the next fifteen years [Unison estimate 650,000]. This should not be a continuation of very low paid, highly insecure, mainly untrained workers but a re-valuing across the board with a Living Wage as a minimum and full employment rights. The RSC resolution to the Labour Party and it [LP] raising a national social care policy together with its economic and social strategy has to be put forward.

#### ***5/ Response to the STP/ Integrated Care Systems agenda***

This NHS led agenda on integration is being responded to by Keep Our NHS Public/Health Campaigns Together. The point to make in relation to adult social care is that local authorities and social care in general are adjuncts to this development, and far from being equal players, find that the agenda and direction is coming from senior NHS mandarins, with little concern for accountability mechanisms or parity of funding. There needs to be at least a National Social Care Plan and funding strategy to go with it to match the NHS 10 Year Plan. It is also worth looking seriously at the example in Scotland where in 2014 the Public Bodies [Joint Working] [Scotland] Act introduce mandatory joint working mechanisms and accountability, and agreed joint plans where health and local authorities have to work together

with agreed budgets and priorities. It is worth noting too that the purchaser-provider split was abandoned there some time ago. And personal social care is free [with top-up accommodation costs for residential care].

### ***6] People as assets and co-production***

There are various forms of partnership working of a public-public nature which can be encouraged in a new adult social care settlement. That does not rule out some private and market-based solutions where people and local authorities find them appropriate and effective, but given both market failure and the demands of profit-taking in residential and domiciliary care [13% profit business models in res. care and indebtedness leading to large firms also failing, LAs over-paying for sub-standard domiciliary care, etc.] compulsory competitive tendering should be replaced by national social care requirements which allow local authorities the scope to develop their own optimal delivery models and local accountability. At the same time the voice of users and carers across the sector from the independent living movement to carers forums, autistic societies, pensioner groups and mental health associations have to be actively encouraged as full partners. Co-production is only a start as it was never designed to generate public-public partnerships, but can nevertheless be a springboard of learning.

Social enterprise and community interest companies are undoubtedly part of any solution in many places, and New Economics Foundation show how best some of these can fit with local authority aims and policy. Any local partnership needs to subscribe to national care requirements and universal principles [to be enshrined in law] and be party to local authority accountability.

Gordon Peters, February, 2019

## **Sources and references:**

Health Campaigns Together[HCT] – Reclaim Social Care model resolution on a universal social care service. This is intended for adoption by HCT and by the Labour Party.

A fork in the road: Next steps for social care funding; Kings Fund and The Health Foundation, May 2018

Richard Murray: Hypothecated funding for health and social care- How might it work?, Kings Fund, May 2018

Simon Bottery: Should free personal care be available in England? Kings Fund, 2018. Bottery outlines how since the 1999 Royal Commission on the future of social care [Sutherland] recommended a system of free personal care- and many reports since then – it was only implemented in Scotland.

See also Professor Dame June Clarke: Annual Jack Jones Lecture, October 2017 on last twenty years of unresolved funding and strategy, and example of mandatory collaboration between health and social care in Scotland <https://www.healthcampaignstogether.com/.../2017%20J%20LECTURE%20LEAFLE...>

The Public Bodies [Joint Working][Scotland]Act, 2014 <https://careinfoscotland.scot/.../legislation.../public-bodies-joint-working-scotland-act-20...>

Westminster Health Forum Keynote Seminar, 15 Jan.2019: Next Steps for Adult Social Care in England – funding, service redesign and policy.

[publications@westminsterforumprojects.co.uk]  
Particularly speeches by Prof. Martin Knapp, PSSRU;  
Ed Moses, Director of Transformation of Care, DHSC;

Niall Dickson, C.E. Health Confederation;  
Aileen Murphie, Director, National Audit Office

Professor Carl Jagger, Institute for Ageing, Newcastle University – various works on epidemiology of ageing and impact of an ageing population

New Economics Foundation:

[How to build a better social care system](https://neweconomics.org/.../an-alternative-future-for-social-care-does-exist-and-we-n...)

<https://neweconomics.org/.../an-alternative-future-for-social-care-does-exist-and-we-n...>

June, 2018. And

[Social care as a local economic solution for the West Midlands](https://neweconomics.org/2017/08/social-care-local-economic-solution-west-midlands)

<https://neweconomics.org/2017/08/social-care-local-economic-solution-west-midlands>

Professor Sue Himmelweit's Womens Budget Group

See for instance:

Changing norms of social reproduction in an age of austerity: Susan Himmelweit..

[iippe.org/wp/wp-content/uploads/2017/01/suegender.pdf](http://iippe.org/wp/wp-content/uploads/2017/01/suegender.pdf)

ICF/GHK and Skills for Care: [The Economic Value of the Social Care Sector in England](#). 2013.

Ann Bannister: [What is wrong with the 'cap and floor' system of funding adult social care](#), 25 February, 2019

[unpublished]. For explanation and proposal on 'cap and floor' see:

Dilnot Commission on Funding of Care & Support [\\_](#) Age UK

<https://www.ageuk.org.uk/information-advice/care/dilnot-commission/>

On needs projection and necessary financing see:

[Allocative efficiency of health spending on older people](#) | The Health Foundation and Institute for Fiscal Studies

<https://www.health.org.uk/research.../allocative-efficiency-of-health-spending-on-olde...>

Buurtzorg model -

Neighbourhood care model from The Netherlands, with some implementation in Britain

[www.buurtzorg.org.uk/](http://www.buurtzorg.org.uk/)

<https://www.buurtzorg.com/about-us/buurtzorgmodel/>

Qulturum is the Swedish co-learning system of health and social care constant improvement based on valuing the care process

National Centre for Independent Living - Carers UK collates and organises information and campaigns regarding rights to independent living

<https://www.carersuk.org> › News & campaigns › News › National Directory

There are many other sources on rights, policies and user and carer organisations, and examples, which I do not list here, for brevity.