Lords Select Committee
Social care funding in England

Women's Budget Group response

October 2018

About the Women's Budget Group

The Women's Budget Group (WBG) is a network of leading academic researchers, policy analysts and activists set up in 1989 to analyse UK government economic policy for its impact on women and to promote policies that will increase gender equality.

Our vision is of a gender equal society.

Our mission is to promote greater gender equality in policy making and raise awareness of feminist approaches to economics.

We do this by producing well-respected, academically robust analysis of the gender impact of economic policy in order to influence policy discussions and promote gender-equal policy outcomes

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Current situation of social care

1. Increases in healthy, disability free life expectancy have not kept up with rising life expectancy, so that the average number of years in the life course that people experience care needs has risen. This combined with population growth has resulted in a growing number of people in need of adult social care. Since 2001, the number of people aged 85 and older has increased by 33%, and those aged 65 and over by 22%.[1] It is estimated that 2.9 million people in England have long term conditions requiring care, 1.9 million more than in 2008.

2. Severe cuts to local authorities' incomes and the restriction of the eligibility criteria to receive care has resulted in an increasing number of people with unmet care needs. The number of adults in receipt of adult care services since 2008/09 decreased a third, from 1.5m to 1m in 2013/14, with the largest decreases for those receiving meals and day care services.[2] Over 1.2 million people aged over 65 do not receive the care they need in essential daily activities – this rises to over 1.5 million when taking into account instrumental activities, such as managing medication.[3]

3. The care workforce is dominated by women in precarious jobs with a high turnover of staff. Few workers have qualifications and their informally acquired skills go largely unrecognised.

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[1] Care Quality Commission (2016) *The State of Health Care and Adult Social Care in England 2015/16* (p 42, Figure 1.16.)
[2] Age UK (2014) *Care in Crisis 2014* (http://bit.ly/2mMSMAE)
[3] Age UK (2018) *'Why call it care when nobody cares?'* (http://bit.ly/2NueZz6)

Only 34% of the workforce had achieved or was in training to achieve a 'Care Certificate' and 70% of local authorities make no provision for training in their contracts with providers.[4]

4. There are 6.6m people providing informal care to a relative or friend in the UK. Women aged 50-64 are the group most likely to be informal carers, with 63% of those who are carers providing care for at least 50 hours a week.[5] With record levels of women in employment and rising employment levels among women of all ages, the supply of informal carers can only be expected to fall.

5. The burden of care should not fall disproportionately on badly paid workers, relatives and friends – or on women (58% of informal carers and 84% of paid carers are women[6]). Any model of funding for adult social care should pick up the cost collectively and spread paying for it evenly across society and generations.

Gaps in funding

6. At the same time as demographic and social trends are putting pressure on social care provision, local authorities' (LAs) funding has been slashed. Current calculations of the size of the social care "funding gap" give estimates of the amount needed to maintain provision at the 2015 level (£1.5 billion in 2020/21 and £6.1 billion by 2030/31), and sometimes of the amount needed to return to the higher levels of provision in 2009/10 (36% more than is currently being spent, with future funding gaps estimated to be far larger).[7]

7. Another £1.3bn is needed urgently even just to stabilise the current social care market, a system that, even if the gap is closed, is providing inadequate care. Spending by councils on care per resident adult decreased 11% from 2009/10 to 2015/16 and nearly 20,000 people are receiving just 15-minute personal care visits.[8] However, even in 2009 social care was widely seen as poor quality and underfunded. In 2006, the Wanless report found 'areas of significant shortfall in what [the social care system] achieves. Some of this is the result of poorly delivered services, but it is also caused by limited funding and other resources'.[9]

8. The 2% precept in Council Tax to fund social care and the additional £2bn in the 2017 Spring Budget are not enough to cover the funding gap. They are not a long-term solution for funding social care.

9. Relying on the Council Tax precept and on the retention of business rates to fund social care is insufficient and contributes to regional inequalities. It disadvantages poorer local authorities and their residents, since local authorities with lower receipts from business rates are likely to be those with the poorest populations and the highest social care demands. This can result in the poorest localities having to charge a higher rate of Council Tax to fund social care, even though their residents can least afford this.

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[4] Skills for Care (2018) *The state of the adult social care sector and workforce in England* (http://bit.ly/2BXrrVL)
[5] Carers UK (2018) *State of Caring Report* (http://bit.ly/2zR6Q4a) p 2
[6] ONS (2018) *Employment by occupation April-June 2018* (http://bit.ly/2QzlD9e)
[7] The Health Foundation (2018) *Social care funding options – How much and where from?* (http://bit.ly/2C9k39M)
[8] Disability Rights UK (13 February 2018) *'Almost 20,000 people still receiving 15 minute personal care visits'* (http://bit.ly/2PlippD)
[9] King's Fund (2006) *Wanless Social Care Review : Securing Good Care for Older People – Taking a Long-Term View* (http://bit.ly/2Eazbqg)

Alternative model of funding

A non-market approach to care

10. Care is a relational activity, in which the quality of the relationship between care giver and receiver is crucial. There may be some ways in which technology can be used to make care provision more effective and possibly enable some people with just a single disability to manage without care services. However, in general it should be recognised that it will not be possible in the relational side of social care to emulate the productivity gains that can be expected in other industries though the use of new technology.

11. This means that the time it takes to provide good quality relational care cannot in general be reduced. Because the care sector is highly labour-intensive, costs can therefore only be cut by employing fewer people or employing more vulnerable or less-qualified staff to be paid less. This inevitably leads to lower quality care. Privatisation was supposed to improve quality through consumer choice, but since the margin for profits is minimal without compromising quality of care, the result has been lowered quality and worse working conditions.[10]

12. For consumer choice to drive quality, there needs to be information, ability to make choices and mistakes that can be costlessly rectifiable. None of this can be the case with social care, as there is little choice in practice, decisions are frequently made in emergency and the information available is often not what is most relevant.[11] In particular, the quality of relationships can only be assessed retrospectively and forming them anew is very costly and disruptive.[12]

Current funding model not fit for purpose

13. In the current situation, the state only funds a part of all paid care, and for the very poorest; the rest is paid out of pocket by individuals. Self-funders, without LA involvement, bought care estimated at £10.9bn.[13] This is dwarfed by the value of unpaid care which comes at zero-cost to the state, but at great opportunity cost to many who provide it.

14. The current funding model of means-testing is not justified. Healthcare is universal and free at the point of delivery and so should social care be, as they operate on the same basis. In both, the need for care is based on a diagnosis of a health condition. As the Communities and Local Government Select Committee mentions in their June 2018 report on funding for social care, the difference between the two systems currently introduces an unfair distortion based on the type of diagnosis; a patient with cancer receives nursing care free of charge under the NHS, while a patient with dementia has to pay for it.[14] The current means-testing

[10] S Himmelweit (forthcoming) Care as investment in social infrastructure, in C Berry (ed) *What We Really Mean When We Talk About Industrial Strategy*
[11] Communities and Local Government Select Committee (2018) *Long-term funding of adult social care* (http://bit.ly/2E7RwEx)
[12] S Himmelweit (forthcoming) Care as investment in social infrastructure, in C Berry (ed) *What We Really Mean When We Talk About Industrial Strategy*
[13] NAO (2018) *Adult social care at a glance* (http://bit.ly/2zTElCU) p 10
[14] Communities and Local Government Select Committee (2018) *Long-term funding of adult social care* (http://bit.ly/2E7RwEx)

model is in practice a diagnosis-based and thus largely random wealth tax for people with assets over £23,250, since it does not apply to wealth-holders who do not need care.

15. For those who need to pay for social care, a private insurance model is not adequate either. People tend to underestimate the care costs they will have later in life. Only those who know they are likely to need care (and will not have relatives to provide it) would sign up for private insurance and so adverse selection would mean insurers would charge premiums that would be too expensive.[15]

Create a National Care Service

17. Because neither a private care market nor a means-tested funding model would be effective in addressing the care needs of the population, the best model for providing people with the good quality care they continuously need would be to provide it free at the point of need, while linking up the new system effectively with other sectors to improve and reduce the social gradient in people's healthy life expectancy.

18. These efforts would involve the creation of a National Care Service, similar in standing to the NHS and closely linked to it. The National Care Service would locate overall responsibility for care provision in the public sector, though it might also fund some provision by non-profit organisations. The goal would be to move away from reliance on private for-profit services, which, due to the minimal margin of profit in the care sector and tendencies for competition to reduce quality (see above), tend to offer minimal quality care.[16]

How to fund it

19. Creating a National Care Service in which care is free at the point of use would require a considerable amount of money to finance it. Funding for a NCS should come from general taxation across a variety of sources, as local taxation as it stands is insufficient and geographically unfair (see above).

20. Various forms of taxation could be raised and/or reformed to provide more funding and a better distribution of how people contribute to it. For example, both council tax and national insurance are regressive taxes, at least over some income ranges, and could be reformed to be both more progressive and raise more revenue Inheritance tax is currently easily avoidable and could be reformed to contribute to social care funding. In general considering some form of progressive wealth tax should be prioritised, in order to spread the burden more evenly than the current system but also because wealth is so unequally distributed regardless of care needs and has a strong intergenerational dimension along the same lines as the provision of long-term care (with relatives providing care across generations).

Social care as an investment

[15] Ibid.

[16] S Himmelweit (forthcoming) Care as investment in social infrastructure, in C Berry (ed) *What We Really Mean When We Talk About Industrial Strategy*

21. Public expenditure on social care is treated as current spending, coming from the current account. Only expenditure on physical assets is counted as investment coming from the capital account. This ignores the crucial role of care in building up human and social capital and biases capital expenditure towards physical infrastructure, at the expense of investing in social infrastructure, which includes health, education and care services.

22. The initial costs of setting up a National Care Service would undoubtedly be expensive. But costs would reduce in the long run as healthy life expectancy would improve and thus the need for care would fall. Moreover, the creation of jobs would also bring in additional tax revenue which will contribute to lowering the net cost of funding the services.[17]

23. Analysis by the Women's Budget Group has shown that investing public funds in child and eldercare services is more effective in reducing public deficits and debt than austerity policies. Investment of 2% GDP in childcare and adult care would create 1.5 million jobs, twice the same number as the equivalent investment in construction.[18] Since investment in care services enables unpaid carers to take employment, the labour supply would also increase, thus expanding employment. This would reduce the net cost of that spending by the revenues generated that extra employment would bring in.

24. Sweden provides universal and comprehensive social care to all citizens who need it. Social care is mostly financed through general taxation. Cost sharing is minimal and provision is generous. There are limits on the maximum amount individuals pay out of pocket for their care needs and co-payments are income related. Out-of-pocket spending is low compared to other OECD countries, at just 3-4% of total expenditure.

25. Denmark provides equal and free of charge access to social care to all its legal residents. It is financed by local taxation and block grants from the state, to a total of 4.5% of GDP in 2010. Coverage is very high and almost everyone who has severe impairment receives formal care (94% of individuals aged 65+ with severe impairments received formal help in 2010). Since long-term care services are to a large extent institutionalised, publicly funded, available and guaranteed, Denmark has one of the lowest rates of informal caregiving in Europe. Informal carers are nevertheless well support and receive a care allowance to compensate for lost wages.[19]

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[17] Ibid.

[18] WBG (2016 *Investing in the Care Economy: A gender analysis of employment stimulus in seven OECD countries* (http://bit.ly/2ivi7kJ)

[19] WBG (2016 *Investing in the Care Economy: A gender analysis of employment stimulus in seven OECD countries* (http://bit.ly/2ivi7kJ)