# Women's Budget Group response to Labour National Policy Forum consultation
# Rebuilding a public NHS

The Women's Budget Group welcomes the Labour Party's commitment to an adequately funded, publicly provided NHS. We also welcome the recognition that social care has to be considred alongside health policy. The split between health and social care can seem arbitary, is dysfunctional and unfair to the workers and users of each service.

Inadequate funding has led to a strained health service and a care system in crisis. Women – as the majority of patients, those receiving care, health and care staff and unpaid carers – have borne the brunt of these impacts. Labour policy needs to reflect the gendered nature of health and care and consider the impact not only on those needing health or social care, and the paid workforce, but on unpaid carers who fill the gap when public provision fails.

**The WBG recommends :**

- Spending on health and social care should be recognised as an investment in social infrastructure, which is as important to society as the physical infrastructure of roads, rail and telecoms.
- Priority should be given to investment in public health and community-based care
- The establishment of a National Care Service that provides carefree at the point of delivery and integrated with the NHS and is funded from general taxation at the national level to avoid the entrenchment of regional inequalities.
- Substantial and longstanding investment in the training, career development and pay progression of both social and health care workers so they have equal standing. To achieve this social care needs the equivalent of Health Education England with a statutory duty to direct training and workforce planning. Only then will consistent and rising standards be achieved. Common training in the first year would help to establish collaboration between the two services.
- Greater recognition and support for unpaid carers without whom formal social care services would be unsustainable.
- Regulation should ensure that conditions of employment for everyone should be compatible with reasonable care responsibilities and disabilities, which should not disadvantage people in their careers.
- Returning direct provision of both domiciliary and residential care services back to local authorities in order to end reliance on private-for-profit providers of social care, starting with private equity firms and hedge funds which should have no place in the provision of social care.
- Increased funding by both local and central government to restore and develop local services including public transport, libraries, parks and other community leisure facilities which are so essential to the health and wellbeing of all - young and old.

## Funding for the NHS

### Impact of funding shortfalls

The devastating effects of the shortfalls in funding for the NHS are well-documented (see for example WBG Briefing 2018).[1] Women have been affected by in a number of ways. For example, admissions to hospital to give birth is the single largest cause of admission to NHS hospitals in England.[2] Nearly half of England's maternity units closed to new mothers at some point in 2017. Capacity and staffing issues was the most common reason.[3] The Royal College of Midwives reports a shortage of 3,600 in the profession.[4]

Women have also been affected by cuts to funding for primary health services which fell by 4% between 2010/11 and 2016/17.[5] Among other things, this is associated with a fall in GP numbers by 5% in the decade to 2016.[6] Women use GP services more than men with a consultation rate that is 32% higher, in part due to reproductive-related consultations.[7]

Women have also suffered from reductions in funding for public health services. The 2013 transfer of responsibility for public health services to cash-strapped local councils was associated with major cuts and public health funding is expected to be reduced by 14% between 2015 and 2020.[8] In 2015 responsibility for health visiting was transferred to local authorities. Since then the workforce is reported to have fallen by 20%. The Royal College of Nursing has expressed serious concern about cuts to local authority children's health services with falling numbers of health visitors and school nurses.[9]

### Need to invest in public health and community based services

We therefore recommend that public health and community-based services receive immediate attention. We are concerned that the transfer of responsibilities for public health to local authorities has resulted in wide regional disparities in provision. For example, the proportion of 6-8 week reviews completed for new born children varies from only 57% in London to over 90% in the North East and in some areas is as low as 10%.[10]

There is evidence to indicate that the strain on acute hospital services can be reduced by strengthening community provision for health and social care.[11] The last 8 years have seen a steady growth in all areas of hospital activity. Emergency admissions have risen by 14% since 2008/09. [12] Evidence indicates that up to 50% of hospital beds are occupied by people who could be cared for in community settings.[13] Cuts to health and social care services simply lead to increased costs for emergency interventions.

However, an evaluation of the ongoing transformation initiative has raised concerns about implementing such a profound transition in health services at a time when the NHS is experiencing the greatest funding constraint in history, social care is being dismantled while demands on the health service are increasing due to demographic and other factors. Despite the rhetoric around the shift to community based care, this has not been backed by resources. In the nine years to 2012/13 the proportion of NHS funds spent on core hospital services increased from 46% to 48% while the proportion spent on community and primary care services combined fell from 36% to 34%.[14] Measures to avoid hospital admissions and accelerate discharges require there to be sufficient capacity and funding of alternative forms of care in the community. Lack of

community provision in the context of reducing the shareof hospital care raises many risks, including the potential burden on unpaid care.

Women are more likely than men to be carers. We are concerned that an increase in community based care that is not matched by sufficient resources will put greater demands on women both as patients and as carers. For this reason we would like to see community health services prioritized before a shift to greater community care. There is more on social care and women below.

**A publicly delivered NHS**

We agree that the adverse outcomes of privatization should be reversed. In particular profiteering of private equity investors from the privatization of social care needs to be addressed.[15]

However, our position is that reforms need to go beyond ownership to reconsider some of the internal management mechanisms within the NHS such as Payment by Results and other finance-based rewards for meeting targets within the health system. These have been shown to be ineffective and to have adverse effects: "history suggests a degree of pessimism about using financial levers to achieve complicated, longer-term aims like increases in the standard of care."[16] The methods by which financing is organized within the health system needs to be reviewed.

## Funding for Social Care

**Impact of the funding crisis**

Social care is in crisis, exacerbated by nearly a decade of austerity together with increased privatisation. In England,[17] 1.4 million people over 65, one in seven, now have unmet needs for help with tasks such as getting up, washed and dressed[18]. This is a 20% increase in just two years. Despite growing numbers of older people, spending on adult social care fell by 8% in real terms between 2009/10 and 2016/17[19] and an estimated 400,000 fewer older people received publicly supported social care as the eligibility criteria were tightened in response to insufficient resources.[20]

At the same time, many people are having their opportunities in life restricted by giving long hours of unpaid care, preventing the numbers with unmet needs rising even higher. Between 2000 and 2015, men and women over 50 increased the time they spent on unpaid care by 15% and 21% respectively.[21] Long hours of care-giving not only restricts carers' own life chances, but also generates significant gender inequalities in the labour market, because women take on unpaid care responsibilities more readily than men.

**Care markets**

The social care market is fragmented and dysfunctional. Almost all (97.5%) of domicilary care is provided in the independent sector and it receives 80% of its funding (including Direct Payments) from the public sector. This contrasts with the residential care sector in which 41% are self funders whose fees, in the more affluent parts of the country can help make up the deficit arising from the increasingly inadequate fees paid

by local authorities. The market comprising almost 8,000 domiciliary social care services in 2017,is itself unstable. The Care Quality Commission (CQC) registration data suggest that in 2016-17 2,000 new domiciliary agencies registered and 1,600 deregistered. The CQC does not record the size of the agencies they manage. Such 'churning' of the workforce *and* their employers is not desirable when continuity of care is an essential dimension of good care. Vacancy rates more than doubled between 2012-13 and 2017-17 to 9% and among nurses working in social care it tripled in that period to 12%

The size of residential care providers varies hugely and there is considerable and long standing concern about standards of care as well the working conditions of the staff. The five largest residential care providers account for a fifth of all residential care places and are based on a business model totally unsuited to the provision of residential care. WBG support policies which would end the heavy dependence on the private sector, starting with stopping hedge funds and private equity firms from owning care homes which contribute to the instability in the care sector. "Financial engineers and junk bond opportunists should not not be the natural owners and funders of large care home".[22]

These complex multi-level corporate structures based abroad undermine any kind ofaccountability, avoid paying any UK corporate tax and bring returns of 12% to their investors at the same time as complaining about the rise in the minimum wage and low fees paid by the local authorities. The Care Quality Commission needs greater powers to regulate local authority commissioning practices. Meanwhile, WBG welcome Unison's Ethical Care Charter and Residential Care Charter supported by the Housing, Communities and Local Government Select Committee.[23] These have subsequently been adopted by some local authorities as a way of improving standards for care workers

**Funding gap under-estimated**

One effect of the current underfunding of social care has been to shift norms towards an acceptance of poor standards of care. 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).[24] However, those making such estimates no longer tend to note that even in 2009 social care was widely seen as poor quality and underfunded. Indeed, 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".[25]

**Spending on social infrustructre should be seen as an investment**

The benefits of spending on social care are widely ignored, largely because it is seen as welfare spending the long-term effects of which are rarely assessed, and a cost rather than an investment. National accounting rules enshrine that bias, by counting expenditure on physical assets alone as investment from the capital account, while all expenditure on care, even though it builds up human and social capital, comes from the current account.

To remove the bias against investment in social infrastructure, all investment should be evaluated in the same terms. This will require developing new accounting methods to guide public policy. Although the public

are not necessarily particularly interested in accounting methods, it would be important to explain why they are being adopted and to incorporate them, not the SNA classification, in any revised Fiscal Credibility Rule.

Massive investment in our social care infrastructure is now needed. Not only will the country gain the future benefits of such investment, it will also gain in the short-term by employment and growth being created. Investment in social care has long term benefits, but it also leads to far greater employment benefits in the short-term than investment in physical infrastructure. For example, research by the Women's Budget Group has shown that up to 1.5 million jobs would be created in the UK if 2% of GDP was invested in the care sector, compared to 750,000 for an equivalent investment in construction, the typical focus of physical infrastructure investment.[26]

Even though employment rates are currently high, many people are not employed for as many hours as they want or in jobs that fully use their skills. So there remains an argument for stimulus spending to give workers more bargaining power and to boost employment prospects. And if projections for the levels of unemployment that will be created by Brexit or by technology replacing workers in the future are correct, such stimulus will continue to be needed. Given the projected shortage of care, it is much more sensible that people be employed to deliver high quality care than be left unemployed.

Indeed, the care industry is, and is likely to remain, one of the few growth industries. Investing to ensure that the care provided is of high quality, and thus sustainable in terms of social relations and the environment, can only be a good thing. Because the labour demands of good quality care will remain high, more and more of us will be spending our time providing care in any desirable and sustainable future.

Further, unlike most other forms of investment spending, investment in care also increases the labour force, by enabling those currently doing unpaid care to increase their level of employment. Thus, even in times of near-full employment, investment in care expands the economy and thus its tax receipts. Even though expansion of the economy and increased tax revenue should not be the ultimate gaol of care provision, or indeed of any policy, these two effects counter the unwarranted criticism that investment in care is unaffordable.

**Creating new institutional structure for the care industry**

A new National Care Service (NCS), working closely with the NHS, is needed. The NCS should provide care and other forms of support free at the point of use to all who need them. It should also be charged with developing policy and making investments so that people of all ages and abilities retain, and hopefully enhance their capabilities.

Putting that into practice will entail what has been called "co-production". This includes "professionals and citizens shar[ing] power to plan and deliver support together, recognising that both have vital contributions to make in order to improve quality of life for people and communities".[27] Such an idea differs from current practice in that: decision-making power is shared, not just users consulted; support is planned, not just reactive to immediate needs; users contribute to that support in whatever way they can, so that others do not just "do for" them; the aims are not only to benefit individuals but also the community as a whole; and it is recognised that even those with reduced capabilities can contribute to that. Co-production methods are

thought to be particularly suitable for developing preventative strategies, such as investment in retaining capabilities into the future.[28]

In a care system made up of private-for-profit providers, consumer choice cannot adequately guarantee the quality of care provided by profit-seeking institutions, because cost competition will dominate quality considerations. For the market to police quality, consumers need to be well-informed, able to make choices and put them into practice, and mistakes need to be rectifiable at no cost. None of these conditions are satisfied for care. Instead, the quality of relationships is hard to assess without experiencing them, choices are often made in emergency situations with a limited set of available alternatives, and changing providers is always costly since new relationships need to be built. The key conditions for the successful exercise of consumer sovereignty are simply not met when it comes to the market for care. As a result, care that is produced for profit tends to be of poor quality, and the scandals that regularly occur in the current system are not so much exceptions as the tip of an inevitable iceberg of systemic failure.

This is not to say that all existing for-profit providers are delivering low quality. Some do an excellent job in poor conditions. But they do so despite the need to make a profit, rather than because of it, and they are often private-for-profit enterprises only because that is the only institutional form currently available to most small providers. Although they often provide higher quality, small providers have difficulty competing financially in an industry that is increasingly dominated by large chains that cut costs to achieve high rates of return in an essentially low risk industry where large providers are simply too big to fail.

Delivering high quality care through the principles of co-production will require repudiating the profit motive and developing new institutional forms for care provision. The National Care Service would be in essence a public sector institution; however to foster co-production and innovation it should be open to collaborations with other non-profit oriented enterprises and co-operatives. In transitioning to such a system, the large chains should be brought into the public sector but smaller providers that can demonstrate high quality, good employment practices and a willingness to adapt should be offered grant funding provided they become non-profits and work to locally set objectives. Excellent work by the Labour Party in developing new forms of ownership might be very relevant to solutions here.

Currently social care is largely provided in people's own homes. Any transition to residential care then comes so late, and in response to such extensive care needs, that no-one would willingly choose to make it. Other countries have a wider range of housing possibilities for the elderly than in the UK, some that enable a relatively seamless increase in care support. New institutional forms of housing should therefore be developed to make such housing a reality in the UK.

This should enable more coordinated, collective forms of care too. For example, local care centres could be set up that include a day centre, sheltered housing and a residential home, from which domiciliary services are run so that people can seamlessly receive the level of care they need and retain/develop capabilities and relationships in their own community. Such centres, if made sufficiently desirable, should have the side effect of freeing up under-occupied accommodation and so contribute to reducing the housing shortage. They should also help with keeping people active longer, safe in the knowledge that the level of care that they need in the future will always be available without disrupting their current social relations and support.

## The NHS workforce

### Rising unfilled vacancies

Women make up 77% of the NHS workforce[29] with more female nurses alone than male staff in every category combined.[30] We are acutely concerned about the conditions facing the NHS workforce as reflected in the rising numbers of unfilled staff vacancies. There are suggestions that the number of staff vacancies could rise from the current level of around 100,000 NHS staff vacancies (1 in 11 NHS posts are unfilled) to 250,000 by 2030.[31] The highest numbers vacancies are in nursing and midwifery, with 38,000 vacancies. Women make up 89% of staff in these categories.[32] Meanwhile the numbers of consultants (two thirds of which are men[33]) has increased by 64% since 2004.[34]

Staff shortages are due to both fewer numbers entering health services and staff leaving the NHS, with a "worrying" number leaving at younger ages. There has been a failure to train sufficient numbers of staff with a large decline in the number starting nursing after the early 2000s. [35] A loss of bursaries led to an 18% drop in applicants for nursing places between 2016 and 2017, the biggest fall in nursing applicants on record.[36] The number of nurses in training are low by international standards (half that of the USA or Australia).[37]

The number of health visitors and nurses leaving the NHS increased by 25% from 2012 to 2018 (from 27,300 to 34,100). [38] Brexit has worsened the situation with a net inflow of nurses from the EU to the NHS becoming a net outflow by 2018.[39] Restrictions on non-EU immigrants have also affected recruitment.[40] Furthermore, the nursing workforce is aging with nearly a third of qualified nursing, midwifery and health visiting staff over 50 years old. One in three is expected to retire in the next 10 years.[41] Numbers of GPs are also falling despite an NHS had a target to increase the number of FTE GPs between 2014 and 2020 by 5,000.[42]

We are concerned for the effect that lack of staffing has on sustainability of services. A 2017 staff survey showed that less than a third of staff (31%) felt there were not enough staff to do their job properly with 29% of staff and 50% of consultants saying they had witnessed errors, near misses or incidents that could have hurt patients and service users.[43]

Lack of staff retention reflects the underlying working conditions for the (predominantly female) workforce. Staff are leaving due to increasing workload and declining morale. A 2017 staff survey reported that 38% of staff had felt unwell during the previous 12 months due to work related stress and 58% of staff are working additional unpaid hours. [44] Lack of staffing and resources more generally is contributing to staff burnout.

When clinical professionals leave they are not easily or quickly replaced. The workforce crisis is regarded by commentators are just as critical as the financial one.[45] While funding is required to boost staffing levels, there are calls by some for improvements in staffing planning. The lack of a "credible workforce strategy" has been described as the biggest internal threat to the sustainability of the NHS, posing a real risk that the additional funding proposed under the current government (up to £10.5bn by 2023/24) will go unspent if healthcare providers lack the staff to deliver the care.[46] Commentators point to failings in planning and short termist approaches. Wage restraint has led to staff to work as agency staff to increase their earnings with adverse effects not just on NHS costs but also on workplace continuity and coherence.[47],[48] Less stable

staffing is associated with lower productivity performance in NHS acute hospitals.[49] Given the long lead times for training new staff (it takes up to nine years for a new medical student to finish GP training[50]) it is vital that attention is focused in the short term on improving working conditions to improve retention.

**Focus on nursing and midwifery**

We therefore support the Labour Party's call for a sustainable health and social care workforce. We would want this to be focused on the areas that are seeing the greatest need in terms of unfilled vacancies – nursing and midwifery. Attention is needed not just to staffing numbers but also to the demands on NHS staff and to pay levels. We deeply regret the impact that Brexit and immigration policy has had on the NHS workforce. While we welcome medical staff from overseas, we caution against recruitment drives which will risks creating staff shortages abroad.[51],[52]

**Need to address equal pay in the NHS**

In 2017 the overall basic fte gender pay gap for the NHS was 8.6% in favour of men, equivalent to an earnings gap of £207 over that month (compared with a gap of 9.1% across all economic sectors according to the ONS). [53] Nine out of 10 NHS organisations in England had a median hourly pay gap that favoured men. However this varies across staff grades. For the 88% on AFC bands, the pay gap is 3.9% in favour of women. And varies according to age. For younger age groups, the pay gap favours women but this reverses between the ages of 30 and 34 and continues to widen across older age groups. In the NHS as elsewhere the main reason for the pay gap is occupational segregation. Senior doctors and senior managers are the top earners in the NHS and 15.4% of all male staff work in these occupations compared with 3.2% of female staff. Meanwhile a slightly higher proportion of women than men (37.4% compared with 32.9%) work in the five lowest paid staff groups within the NHS.[54]

Higher pay bands with a disproportionate share of men in each band have a (small) pay gap in favour of men. But for the 12% of NHS staff outside afc the overall pay gap is 47% in favour of men. This group comprises junior doctors on relatively low pay and consultants and others on relatively high pay. So for the NHS as a whole a small group of highly paid men outside the afc is affecting the pay gap. Research by the Nuffield Trust shows that the reason for the pay difference is due to "additional pay" – time spent on call, overtime and additional work. This is more likely to be done by men. And the pay gap becomes most pronounced for women in their 30s and 40s. Main likely cause is the negative impact on pay of having children. This will lead to part time working and less likelihood of promotion [55],[56]

The proportion of female GPs exceeded male GPs in 2014 and the share of women has continued to increase. For GPs, the gender pay gap is more significant, with male GPs earning 33% more than female GPs in 2019.[57] We would like to see a commitment to working practices that are supportive of the demands on women and where family responsibilities are not an obstacle to career progression.

## The social care workforce

### Low pay and high turnover

In 2018 the care sector was made up of 1.6 million jobs for 1.47 million people in the UK. Women made up 85% of the 840,000 care workers,home carers, and senior care workers. Half of domiciliary care workers and 18% of registered nurses were on zero hours contracts. The pay is poor, there are long standing disputes over travel costs and pay for sleep-ins. It is not surprising that the turnover rate in 2017-18 was nearly a third. Although they do not all leave the care sector: one third of recruits to a job in the sector come from *within* the sector, vacancy rates more than doubled between 2012-13 and 2017-17 to 9% and among nurses working in social care it tripled in that period to 12%.

### Professionalising paid care

To lead fulfilling lives, people need more than to be able to get washed and dressed, they need to be helped to exercise a full range of human capabilities, to meet others and to contribute to society. But under current conditions, care workers cannot do much about that; they are trained only to do limited tasks as quickly as possible before rushing off to the next client. Despite "personalisation" policies meant to give clients control over spending on their care, limited budgets mean that neither clients nor care workers have any effective say in what care they receive, how it is delivered and by whom, and collectively delivered services have effectively been killed off.

As well as failing to deliver care that really enhances capabilities, the paid care industry is having difficulties recruiting and retaining staff (difficulties that will only be made worse by Brexit). In the face of women's improving qualifications and opportunities to enter other careers, more will need to be done to attract both men and women willing to learn and deliver good quality care into the industry.

To ensure that care is valued properly and leads to the long-term benefits, the notion of what care is for needs to be transformed. Instead of its limited current ambitions, which are largely focused on bodily needs, its focus should be on enabling everyone to reach their maximum potential, with help where necessary, across the full range of capabilities. Care workers should become capability facilitators, work that requires among other skills:

- knowledge of the likely progression of capabilities with age and health conditions, the forms of help that can restore and preserve capabilities and the social resources available to support those in need of such help;
- imagination in finding solutions to meet individual needs; and
- the ability to learn from experience to improve performance.

All these skills can be learned, but they are far more extensive than those that are currently required of care workers, who are seen as simply doing for people what others can do for themselves. It is that view that leads to care being seen as unskilled work – just doing what the rest of us do anyway and/or women do unpaid for others in the family – even though in practice many care workers acquire unrecognised skills and do much to enhance capabilities.

**Training and Career structure in paid care work**

The Women's Budget Group has long advocated for *a substantially increased and sustained* investment in developing the skills and career paths which careworkers need, not only so social care becomes an attractive occupation, but also to improve the quality of care provided. As above this will also deliver for the economy.

Employers currently invest very little in training their staff. Social care workers should have much longer training courses, similar to those for nurses as well as the opportunity to acquire new skills as they progress in a career. Three year training courses for care workers should be developed, based on a different idea of what care should achieve, enabling people to live their lives in the way that they want, rather than simply doing things for them. This would require a complete overhaul of training, so that care workers could draw on the broader set of skills and knowledge needed to care in these ways.The first year could be shared with nursing training as happens in Germany for example. This would improve the much needed collaboration between health and care services, which is much needed. WBG welcome the Labour Party's commitment to re-instating nursing bursaries. A similar scheme should be introduced for social care students. These are particularly important if older women are to be attracted to these courses, especially if part-time study is also possible.

The quality of care is linked to the very low level of training social care workers receive and therefore the skills they develop. Half have no relevant care qualifications and only a third had achieved or were working towards their Care Certificate. This was introduced in 2015, is not mandatory and only designed to train new care workers in the basic skills needed in their day to day work. Dementia care was only included in two fifths of the recorded training categories completed and medication, safe handling and awareness was included in only half . Lack of training in these key areas have immediate consequences for the NHS because one in ten older people's admissions to hospital are linked to their medicine intake, the majority thought to be avoidable.

The shortage of nurses in care and nursing homes also exacerbates the problem of lack of training in medication among care staff. In the 17,000 residential care and nursing homes where the health of the 400,000 residents is more fragile residents are prescribed an average of seven medicines a day, costing the NHS an estimated £250 million each year. Altogether these residents accounted for 250,000 emergency hospital admissions and it is estimated that 30-40% of these admissions would be avoidable with better care and support. In 2019, NHS England as part of their NHS long term plan are trialing a scheme to recruit 200 clinical pharmacists and pharmacy technicians to reduce over-medication in care homes. However it is hard to see how effective they will be without properly trained care workers to support them.[58]

## Improving the conditions of unpaid care

Health and sociall care policy should include consideration of the needs of unpaid carers. The professionalisation of paid care described above should greatly improve standards and, provided it is universally available, should relieve the necessity of anyone having to do unpaid care. However, paid care will always work in tandem with the care that families and friends freely provide. Such care, providing that it

does not become burdensome, can be life enhancing for both carers and those they care for. But to remain part of the mix without causing unacceptable demands on some individuals, it will need to be better supported by good quality reliable professional services and better employment regulation. Women continue to provide unpaid and paid care and the numbers doing so are growing. In 2011 there were 6.6 million unpaid carers in the UK increasing to over an estimated 7.6 million in 2017.[59] At this time there were 1.5 million adult care workers of whom over four out of five were women. The value of the care provided by unpaid carers, three out of five of whom are women, including half aged over 55years, is estimated to have grown to between £100 and £132 billion/year. This compares with local government spending on arranged residential and domiciliary care totalling £20.4 billion.

It is estimated that the number of people aged over 65 who need informal care will grow by more than a million in the next 20 years . Forms of support both for those needing care as well as for carers of all ages include benefits and services. In addition, the demands of paid work, education and training need to be made more compatible with time needed to care.

Timid steps have been made and carers have the right, after working 6 months for the same employer , to request flexible hours and five days paid leave a year. There are no figures on the numbers of requests made or granted. The earnings sacrificed by carers who give up or reduce their employment has been estimated to be £17.5 billion/year. The Social Care Act 2014 gave carers the right to have their need for support and respite assessed . However, social service departments have not had the resources to promptly assess the minority who sought support let alone to provide any help. Only one in six of those seeking help received any respite care and most received advice only.

With this in mind, employment should be regulated around the assumption that everyone is both a worker and carer (of children or of adults) and that many in receipt of care are also workers.

Regulations should focus on ensuring that:

1) Conditions of employment for everyone should be compatible with reasonable care responsibilities and disabilities, which should not disadvantage people in their careers.
2) Where they can, employers should be required to adapt conditions to specific circumstances.
3) Individuals should have rights to take leave, without loss of income, for unpredictable or exceptionally high care demands

The first of these would require making normal working hours compatible with caring responsibilities, by regulating the length of the working day and specifying the notice that has to be given of when workers are needed. Rigorous enforcement of working time regulations without exception is essential because any type of work exempted from such regulation would be less open to those with caring responsibilities (and those in need of care).

Currently such people are more likely to be women, perpetuating gender inequality. But even if that were not the case, closing off opportunities to those with caring responsibilities sends the wrong signal about the place of care in society. No job should be considered so important that it cannot be combined with carrying out the normal duties of a carer, or be done by a person with a disability. Nor should those with care responsibilities have to pay for the conditions that they need in lower wages.

Employers should also be required to adapt working conditions to specific circumstances, primarily to accommodate specific disabilities and when a carer has specific needs, for example to make phone calls. Resources should be made available to help with the cost of such adaptation where they are needed just for specific individuals, rather than could reasonably be provided for everyone.

Workers also need individual rights to take time out of employment at times of exceptional caring responsibilities or when existing care arrangements need modification. Paying such leave at wage replacement rate is not only fair but will ensure that income considerations do not influence its take up. Payments should be reimbursed from a dedicated national insurance fund.

Making having caring responsibilities the norm, by assuming all workers to be carers, should encourage an expectation that those without current family caring responsibilities would take up volunteering opportunities, perhaps to provide care or other forms of support to those lacking it from family. A system for organising such volunteering should be developed in local areas.

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