

UNIVERSAL QUALITY SOCIAL CARE

TRANSFORMING ADULT SOCIAL CARE IN ENGLAND

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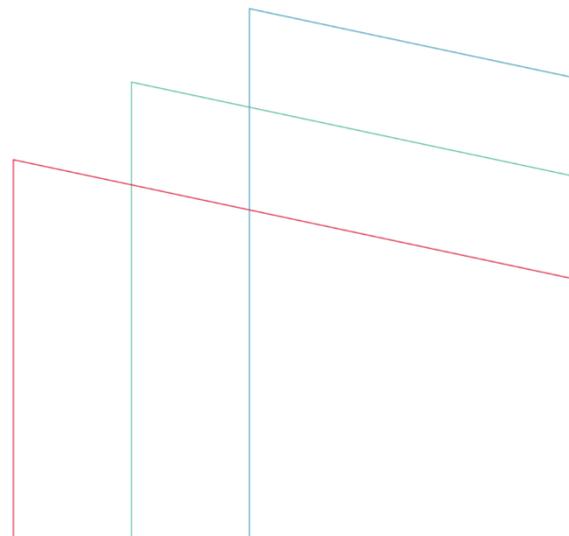
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EXECUTIVE SUMMARY

Successive governments have done little or nothing to tackle worsening conditions in social care, for either recipients of care or care workers. Since the outcry over the failure to stem the spread of Covid-19 in care homes, however, there has been a step-change in the pressure on the government to deliver on their promise to ‘fix’ social care. In September, the government announced plans for a health and social care levy on national insurance contributions, which included an additional £5.4bn spending on social care over the next three years. On 1 December, the government set out a strategy to ‘Put People at the Heart of Care’.

The strategy sets out a transformative vision for care to provide ‘support to those who need it so that as many people as possible can live the life they want to lead’. Such a transformation could be a central plank in building a more caring society post-Covid, where people with additional needs arising from illness, disability, or age have equal chances and increased control over their lives.

The problem is that the government has failed to outline a realistic plan, with a realistic amount of money, to achieve this vision. The government’s attention, and the bulk of the additional money raised, is aimed at ensuring that ‘no one will have to sell their homes to pay for care’ through a cap on care costs. The remaining £1.7bn over three years is totally inadequate to deal with the raft of other issues facing care: unmet needs due to limited access; unsustainable demands made on family and friends; or poor-quality provision, jobs, and working conditions. Unless these issues are dealt with in the round, the opportunities presented by a transformation of social care will not be released.

Criteria for reforming social care

We argue that the issues facing social care have their roots in a common set of causes:

- **Means-testing.** Publicly funded social care is means-tested on both income and assets. Those who fail the means test receive no financial help from the state in organising their own care. It has been described as the meanest means test in the welfare state. A freeze on the upper threshold of the means test has meant it has become increasingly more severe over time. While the government’s latest policy will change the level of the means test and introduce a cap on care costs, the cap is high and only calculated on self-funded care.
- **Underfunding.** Funding cuts have led to local authorities reducing both the number of people they support and the level of support that they provide. One

consequence is that publically funded social care is increasingly reserved for those with the highest needs. Another is that self-funders are charged excessive fees to cross-subsidise local authority commissioned services.

- **Failing markets.** For those using local authority commissioned services, market competition has not achieved its intended aims. Local authorities are pushed towards a short-termist approach of purchasing care packages via competition between providers based on price. To keep costs down, staff-to-client ratios are kept to a minimum, tasks and working practices are standardised, and workforce pay and conditions are suppressed. The quality of care suffers.

Reform of social care, therefore, needs to meet two main criteria. First, it must close the funding gap or the difference between estimated income available to fund services and the cost of meeting all care needs through high-quality social care. This will require a new financial settlement capable of making comprehensive social care free at the point of need, widening the availability of social care, and improving care quality and working conditions.

Investment, however, needs to drive change in social care, not more of the same. So, secondly, reforms must close the implementation gap or the difference between the reality of social care provision and the vision set out in the Care Act's wellbeing principle. This sets out an admirable ambition for care, with similarities to calls for independent living, where the purpose of care is to 'help people to achieve the outcomes that matter to them in their life'.

Proposals for a universal quality social care service

To close the funding and implementation gap, we propose three broad policy solutions:

- **A generous new funding settlement.** In our core scenario for take up, the additional cost of care under a universal system would be £19.6bn per year. Simultaneously raising the rate of pay to the real living wage would require another £12.3bn. This should be the immediate priority.

Our proposals are more expensive than many other, more incremental reforms currently mooted in the debate. Unlike other proposals, however, we have combined the costs of all the reforms needed to assess how much it will need to deal with the issues in the round, rather than dealing with each in isolation. And the revenue is raisable.

Beyond this immediate priority, a transformative care system would extend services to a wider group with moderate care needs while increasing the quality of care through higher levels of training and skills. This in turn would require

higher wages, bringing the pay of care workers in the UK more in line with that of Nordic countries at around 75% of nurses' wages.

- **An expanded role for local authorities.** We propose that local authorities, working with people needing support and their families, should be required to develop and deliver long-term strategies to transform provision in line with the wellbeing principle in the Care Act. This means putting the principle of co-production at the centre of social care. Getting there will involve (1) shifting the organisational nature of provider organisations receiving public money away from for-profit towards providers, and (2) a step-change in the relationship with and between the local state and provider organisations. Rather than short-termist, cost-driven competitive tendering, local authorities should move towards collaboration and strategic partnership in pursuit of shared goals.
- **A new national body to drive improvement.** The creation of a new national body would work with local authorities to transform social care provision. It would set and enforce high standards for both care quality and job quality, and share and spread good local practice. A reformed Care Quality Commission (CQC) should sit under it, alongside a new agency with responsibility for the regulation of the workforce.

INTRODUCTION

Over the last 18 months, the inadequate social care system in England has exacerbated the worst effects of the pandemic. Services on which millions of people rely have not been able to protect those using or working for them. During the first wave, 27,000 people died in care homes in England and Wales, either directly or indirectly because of Covid-19.¹ Care workers died at twice the rate of the general population.² As support was withdrawn, 4.5 million people took on unpaid caring responsibilities.³

The inadequacies of our social care system existed long before the pandemic. Successive governments have ducked reform, deterred by the politics of trying to fund a complex system whose failings are poorly understood by the public until they or their loved ones need care. However, since the outcry over the failure to stem the spread of Covid-19 in care homes, there has been a step-change in the degree of scrutiny on the government and their promise to 'fix' social care. So much so that September saw the government announce their plans.

As we go on to argue, these plans are inadequate. Rather than rise to the scale of the challenge, the government announced plans to cap care costs with the minimal aim of ensuring that 'no one will have to sell their homes to pay for care', though in practice that is not how the current system works, and the government's plans will not protect the heirs of future recipients from having to do so. There are insufficient plans as yet to fix any of the other systemic issues facing care: be they unmet need due to limited access, unsustainable demands made on family and friends, or poor-quality provision and jobs.

Social care transformation should be a central plank in building a more caring society, whose success would be measured in terms of wellbeing and what people can choose to do with their lives. The priority would be tackling the inequality that arises through illness, disability, or age resulting in some people needing support to be able to choose to do what most of us can do unaided. A caring society would ensure that such people's needs are met in a way that as far as possible gives them equality in their life chances and control over their lives.⁴

A caring society would also enable people to provide care without it reducing their own life chances, by ensuring that good quality professional care was freely accessible to all who needed it. The work of enabling people needing care to take control of their lives, rather than 'doing for' them, requires specific training and expertise. In a caring society, care workers would be treated as professionals and rewarded accordingly, within a

proper training and career structure, so that both men and women would be proud to work in the sector.

The costs of not having such a caring society are measured in reduced wellbeing, but even in purely economic terms social care is an investment with wider benefits; better health and wellbeing through preventative care would mean less spent on services putting right the effects of neglect. Social care is also foundational to the economy, directly and indirectly providing jobs in all parts of the country, particularly in poorer areas where the unmet need for social care is greatest, and potentially freeing up unpaid carers to participate in the wider economy. Provided these are good well-paid jobs, they could help tackle regional inequality and declining living standards and contribute to closing the gender employment gap.⁵ Crucially, these are sustainable jobs, not only because demand for care is set to increase in the long term, but also because social care is a low-carbon sector.

In this report, we explore how investment might be directed towards a higher ambition for social care in England. Significant investment is required to create a high-quality universal service that would ensure that people's needs are met in a way that supports their wellbeing, with a well-trained workforce with decent pay and conditions and financial costs shared progressively across society. An ambition such as this would be transformative, for those immediately affected but also for society as a whole. It would provide the security of knowing that if we, or someone we care about, has a disability or health condition during our lives, we would have the support we need.

We start by outlining what we see as the full range of problems with the current system, before moving on to identify the key drivers of these problems. We then set out key criteria for transforming social care and a set of proposals for how we can get there.

THE PROBLEM OF INADEQUATE SOCIAL CARE

This chapter sets out what we see as the full range of problems facing the adult social care system in England. We outline how many people pay very high costs for their care, while others rely on friends and family, who too often have no choice but to provide informal care without support. Increasing numbers of people go without the support they need at all. And for those who can access social care services, the quality is too often poor, with low-paid, insecure workers providing minimal care.

Understanding social care

Adult social care aims to support people with additional needs resulting from illness, disability, or age to have the choices to do what others can do unaided. Some forms of care and support are short term while people recover from an illness or an injury; others are provided on an ongoing basis. Social care takes place in a range of settings, from support in people's own homes – often referred to as either home care or domiciliary care – to support in a care home or nursing home setting – referred to as residential care. It includes care for both working age and older adults. Whatever form social care takes it should meet people's needs for autonomy, dignity, and control.

Care needs are a normal risk of life. Anyone may need care at any point in their adult life because of a disability or a health condition. The likelihood of needing care, however, increases significantly with age. Forty-four per cent of people aged 65 and over in England and Wales have a disability or health condition that limits their daily activities, compared to 17% of those aged under 65.⁶ People aged 80 and over are more than twice as likely to need help with activities of daily living (ADLs) as those aged between 65 and 69.⁷

As well as age, people's chances of needing care are also shaped by their circumstances, because our health is determined by social, economic, and environmental conditions, such as the adequacy of people's incomes and the quality of their work, education, housing, their physical environment, and social connections. Access to these conditions is unequally distributed. On average, healthy life expectancy at birth differs by 12 years between the most and least deprived local authorities.⁸ Fifty-four per cent of women and 38% of men aged over 65 in the most deprived local authorities need help with ADLs compared to 15% of men and 26% of women in the least deprived local authorities.⁹

Catastrophic costs

Many of those who develop care needs have to cover care costs themselves, and the cost burden can be extremely high. The uncertainty inherent in the risk of needing care makes it difficult for individuals to anticipate if and when they will need care, how extensive and long-lasting their care needs might be, and what kinds of support they might be able to draw on.

Around one in ten people, at age 65, faces future lifetime care costs of more than £100,000.¹⁰ As a result, some people lose the majority of their income and assets in paying for care. The average annual cost of living in a residential care home in the UK is more than £36,608, while the equivalent cost of living in a nursing home is £46,176.¹¹ It is worth noting that despite the government's framing of this issue, people are not routinely forced to sell their homes during their lifetime to pay for their care, but their heirs may have to. If someone enters residential care while their partner or former carer still lives in it, they will not have to sell their home. What's more, local authorities offer deferred payment options, whereby the costs are recouped from the sale of a house after the death of the person being cared for.

There is very low public awareness of how social care is currently funded. Most people assume that state-funded care is provided to most people, with the government paying for at least some, or even all, of the care people need. Deliberative research by the Health Foundation and the King's Fund in 2018 found a unanimously negative reaction to the current funding model, with participants shocked when the details of the means test were explained to them and concerned for how they or their loved ones would be provided for in later life.¹² It is widely seen as unfair that if a person has a disability or a health condition such as dementia, they have to pay for their own care, while if they have an illness that is treatable by the NHS, the costs of their care are shared across society.¹³

Much of the public debate about social care, and the government's reforms, focuses almost exclusively on this issue. However, this is by no means the only problem.

Unsupported unpaid care

While some pay excessive costs for care, others with care needs rely on friends and family, who provide informal care with little to no support.

According to the 2011 census, 6.5 million people in the UK provide unpaid care. More recent research suggests that the number of carers is much larger than projections based on the census would indicate, with as many as 8.8 million people estimated to be carers

in 2019.¹⁴ The nature of caring means that each year millions of people take on new caring responsibilities, while others find that their caring responsibilities come to an end. As a result, caring responsibilities are taken on by most of the population, with three in five people becoming carers at some point in their lives.¹⁵

Unsupported, these responsibilities can take a heavy toll. Three million people in the UK juggle work and caring responsibilities, often under significant pressure. It is estimated that 600 people give up work every day to care for an older or disabled relative.¹⁶ The main carer's benefit to replace lost income is very low; restrictive eligibility criteria exclude many carers from receiving it. Meanwhile, carers receive little support from the social care system, other than advice. Over a quarter of carers live in poverty,¹⁷ and those who provide high levels of care are more than twice as likely to be in poor health than people without caring responsibilities.¹⁸ The impacts are disproportionately felt by women, who do more unpaid care than men, making up 58% of carers, and are more likely to give up employment to care for someone.¹⁹

Polling by Carers UK shows a steep rise in the number of people providing unpaid care throughout the pandemic. An additional 4.5 million people are thought to have started providing unpaid care since March 2020. Additionally, 81% of those providing unpaid care before the pandemic found that their caring responsibilities increased, with 38% reporting that this was because of the reduced availability of social care services.²⁰

Inadequate access

Too many people are unable to access support at all and simply go without the help they need.

A lack of data and a range of definitions of 'unmet need' make it difficult to estimate the exact number of people without adequate social care support, but the available evidence indicates that the majority of those with care needs are not getting the support they need. This is a result of some people receiving some, but not enough support, and some people receiving no support at all.

Our analysis shows that 2.1 million people aged 65 and over in England need help with at least one ADL, of whom 84% have unmet needs, equating to 1.8 million people (the appendix has more details). Comparable evidence on the unmet needs of younger adults is lacking, though the Health Foundation has found that 18% of people aged between 18 and 64 report a disability, but only 3% receive formal or informal care. Unmet need is greater in more deprived areas: around two in five people aged 65 and over living in the

most deprived fifth of neighbourhoods in England have an unmet need for help with at least one ADL, compared to one in five in the least deprived fifth.²¹

The Covid-19 pandemic is likely to have exacerbated this problem by increasing demand for social care from a combination of hospital discharge, reductions in family caregiving capacity, and increased levels of poor physical and mental health. While it is too soon to see the extent of this in official figures, nearly half of the directors of adult social services believe there has been an increase in unmet need since March 2020.²²

The impacts of unmet needs on people's lives are often debilitating. The Care and Support Alliance surveyed 4,000 adults with care needs in 2018. One in five respondents reported feeling unsafe moving around their own home and being unable to leave. Over a quarter reported being unable to maintain basic activities like washing, dressing, or going to the toilet.²³

Varying quality of care

For those who can access care services, the quality of care is often poor, failing to meet aspirations to support wellbeing. Care jobs are low paid, with poor conditions, leaving the sector subject to high vacancy and turnover rates, further impacting the quality of care.

The CQC, which regulates social care, defines care quality based on five characteristics:

- Safe: people are protected from abuse and avoidable harm.
- Effective: care achieves good outcomes, helps people to maintain quality of life, and is based on the best available evidence.
- Caring: staff involve and treat people with compassion, kindness, dignity, and respect.
- Responsive: services are organised so that they meet people's needs.
- Well-led: the leadership, management, and governance of organisations make sure that they are providing high-quality care that is based on people's individual needs, that they encourage learning and innovation, and that they promote an open and fair culture.

The CQC rates 84% of social care services as 'good' or 'outstanding'. The remaining 16% of services are rated as 'requiring improvement' or 'inadequate'.²⁴ The providers delivering services that fall below the required quality standard have neither been improving nor exiting the market.²⁵

The bigger issue, however, is that social care services are not generally designed and delivered in a way that is consistent with the purpose of 'help[ing] people to achieve the

outcomes that matter to them in their life', as set out in the wellbeing principle in the Care Act.

Research has shown that people using services think that the social care system does not currently collect data on what matters to people who rely on it.²⁶ Many say their opinions are frequently discounted, they often cannot access data about them, and they often feel dismissed.²⁷ The usefulness of the CQC's ratings is, therefore, limited.

Following a series of listening events with older people and their families, Age UK observed that the majority of the people they spoke to described the poor quality of care that they and family members received.²⁸ As Social Care Futures argue, beginning to use social care services 'can mean that things about our lives that we value are changed without our say, or lost altogether'. Anna Severight, the convener of Social Care Futures, argues 'For me, it's that I want to be able to go out more to see friends but don't have the support to do so. For others, it may be having no option but leaving loved ones and their home to go into institutional care, or not being able to choose what time you go to bed in your own home.'²⁹

Commissioned domiciliary care, in particular, is too often based on the delivery of specific tasks based on the basics of survival, such as helping people to get washed and dressed.³⁰ Social care workers may seek to treat people well, but they lack the flexibility to be responsive to people's needs. A 2016 UNISON survey found that 85% of domiciliary care workers do not have time to have a conversation with the people they are supporting. Seventy-four per cent believe that they do not have enough time for dignified care.³¹ And these essential roles are low paid, with poor conditions.

One and a half million people work in the adult social care sector in England, in 1.2 million full-time-equivalent jobs.³² The workforce is predominantly female and many are from black, Asian, and minority ethnic backgrounds. Jobs are poorly paid, particularly in the independent sector, where mean hourly pay is just under £9 for care workers. They are increasingly insecure, with nearly a quarter of workers employed on zero-hours contracts.³³ And the jobs are also seen as unskilled, with staff unable to access training.

Lack of prestige is widely seen as a major impediment to attracting people to work in the sector. There are limited opportunities and funds for training and career progression, particularly compared with health.³⁴ As a result, the sector struggles to recruit and retain workers. The turnover rate is 30%, equating to approximately 430,000 people leaving their jobs each year.³⁵ This leads to providers incurring regular recruitment and induction costs. More significantly, it disrupts continuity and the quality of care for people using services.³⁶

FUTURE PRESSURES

With rising numbers of people needing care, without significant reform of our social care system, the problems of inadequate access to care, catastrophic costs, and excessive caring responsibilities will affect more and more people. So will the problems of varying care quality and low job quality, unless they are directly addressed.

To provide just the inadequate level and quality of support that the system currently provides, the Care Policy and Evaluation Centre (CPEC) at the London School of Economics estimates that the number of placements for older people using publicly funded care at home will need to rise by 61% to keep pace with demographic pressures by 2038. The number of residential care placements will need to rise 41%.³⁷

While population growth among those aged between 18 and 64 is projected to be just 2.6% between 2018 and 2038, CPEC estimates that there will be an increase of around 57% in the number of younger adults using social care over this period, because of the rising prevalence of learning disabilities, physical disabilities, and mental ill-health. This is both because people with disabilities are living longer, and surviving childhood, and because more people report disabilities and mental ill-health.³⁸ They estimate that the number of placements for younger adults using publicly funded care at home will need to rise by 47% for those with learning disabilities, 14% for those with physical disabilities, and 3% for those with mental health needs.

THE CAUSES OF INADEQUATE SOCIAL CARE

The many problems facing social care have their roots in a common set of causes. This chapter sets out what we understand the main causes to be. First, we describe how the publicly funded social care system reserved for those with the least means. We then argue that that underfunding, combined with the way care is also organised and delivered via failing markets of private providers, competing on cost, has had a damaging effect on care quality and access.

MEANS-TESTING

Publicly funded social care in England is means-tested, rather than universal for those who need help or support. The means test has been described as the ‘meanest’ in the welfare state due to its stringency.³⁹ It is complex and poorly understood by the public.⁴⁰ At the moment, only people with assets below £23,250 are eligible for publicly funded care and they are typically required to contribute towards their care from their income; those with assets of between £14,250 and £23,250 are required to contribute from their assets as well. The means test has become more stringent over time, with the upper threshold of £23,250 frozen since 2010/11. If it had risen in line with inflation, it would have increased to nearly £30,000.⁴¹

In September 2021, however, the government announced planned changes to the levels of the means test and introduced a cap on care costs. This will see a cap of £86,000 on the maximum amount of social care anyone will pay for during their lifetime. The government also increased the income floor to £20,000, below which no one pays for their care. Those with assets between £20,000 and £100,000 are required to contribute to their care costs. The changes to the cap and floor model will only start to take effect from October 2023, and will not apply to people who start their care before then. The cap itself is very high, and will consequentially still lead to people drawing down large amounts of income, savings, and assets to pay for care. In November, the government announced that it would calculate the £86,000 cap only on the proportion of self-funded care. As the Resolution Foundation points out, this could mean thousands of England’s poorest pensioners paying the same price for their old age care as wealthier people, and a much larger proportion of their income and assets.

UNDERFUNDING

Due to cuts to local authority budgets since 2010, access to publicly funded care has increasingly required higher levels of need to qualify for support. The Care Act 2014 introduced new national criteria to assess whether people are eligible for support, aiming to end a 'postcode lottery of variations in eligibility between different LAs'.⁴² These criteria require local authorities to consider whether a person's needs arise from, or are related to, a physical or mental impairment or illness; whether the person is unable to achieve two or more of a specified set of outcomes as a result of their needs; and whether there is, or there is likely to be, a significant impact on the person's wellbeing as a consequence of being unable to achieve those outcomes. There are two main issues with these criteria. The first is that, even if successfully applied, they would leave many people unable to achieve at least one of the eligibility outcomes without access to social care. The second is that they have not been successfully applied in practice. Two years after the introduction of the Care Act, NatCen Social Research found that 64% of older people who should be eligible for publicly funded social care nonetheless had unmet needs.⁴³

Crucially, the legislation was brought in at a time when government funding for local authorities was being cut. Funding decreased by 55% between 2010/11 and 2019/20, resulting in a 29% real-term reduction in local government spending power.⁴⁴ Local authorities sought to protect social care budgets compared to budgets for other services,⁴⁵ but they have had to reduce both the number of people to whom they provide support and the level of support that they provide. The increased reliance of local authorities on local sources of revenue, rather than the central government grant, has particularly disadvantaged deprived areas with a lower tax base and higher levels of need for publicly funded social care provision. Cuts to social care vary around the country and tend to be larger in more deprived areas, where demand for both care and publicly funded care is high due to higher rates of ill health and higher numbers of people with income and asset levels below the means-test threshold. The 30 councils with the highest levels of deprivation made cuts to social care of 17% per person between 2009/10 and 2017/18, compared to 3% per person in the 30 areas with the lowest levels of deprivation.⁴⁶

One consequence is that publicly funded social care is increasingly reserved for those with the highest needs. Effectively, local authorities have had to apply national eligibility criteria more and more restrictively. Despite a rise in requests for support, the number of people using social care has fallen since 2015/16. By far the biggest fall has been in older

people using any form of publicly funded long-term care, which is down by 6.6%, even though the older population grew in that period.⁴⁷

The benefits of early intervention and prevention are widely recognised, both for people's health and wellbeing and for the effectiveness of public services, with the National Audit Office estimating in 2013 that one-fifth of emergency hospital admissions were for existing conditions that could be managed effectively by primary, community, or social care, and could be avoided.⁴⁸ Yet social care is moving in the opposite direction. In the four years before the pandemic, there was a 27% increase in avoidable illnesses and injuries caused by inadequacies in social care for those living with dementia.⁴⁹

Another consequence is increased costs for those paying privately, as independent providers are compensating for low public funding by charging excessive fees to individuals who self-fund their own care. The Competition and Markets Authority has found that self-funders pay 41% more than local authorities for a placement in the same care home,⁵⁰ while LaingBuisson estimates that domiciliary care providers charge around £3 more per hour than the prevailing local authority rate.⁵¹ The cross-subsidisation of publicly funded social care by self-funders effectively amounts to a tax on people who happen to have care needs, rather than expecting all taxpayers to contribute, a more effective and fairer way of pooling risk.

FAILING MARKETS

Social care is provided by a 'quasi-market'.⁵² Providers compete for business from local authorities, who commission care, and from private individuals, who either self-fund their own care or, if they are eligible, cover the costs using direct payments received from local authorities. The state is both a regulator of services and a monopsonist.⁵³ Since 2014, local authorities' 'market shaping' duty has also required them to ensure that there are diverse, high-quality social care services available for people who need them, including both those who fund and do not fund their own care.

The marketisation of social care began in the 1980s and was accelerated by the 1990 National Health Service and Community Care Act, which re-cast local authorities as commissioners rather than providers. The rationale used to justify the introduction of a market in social care was to give people, as consumers, greater choice over their service provider and therefore to align services with their wants and needs, as well as to cut the cost of care by using competition to drive efficiency.

For many of those choosing direct payments, having the option to decide what to spend their allocated budget on has been empowering. Many younger disabled people, who value the control that it gives them over what support they get, and when and how they get it, champion this approach. However, most do not take it up, preferring to receive a service instead. Just 40% of working-age adults and 17% of older people using publicly funded social care in England opt for a direct payment.⁵⁴

There are different reasons for this, but an important one is that, for many, choosing social care in a market can be disempowering. Social care is often, particularly for older people, a ‘distress purchase’, unplanned but necessary because of a crisis. In these conditions, people are often unable to shop around for the best service. Moreover, decisions are sometimes made by third parties, such as a son or daughter seeking residential care for a parent with dementia.⁵⁵ The search for a care home is often urgent and people tend to feel rushed into making a decision. They generally visit only three or four care homes and find it hard to judge their quality. They may have low expectations, seeking the ‘good enough’ option. Once they have moved into a care home, it is very difficult for them to switch to another, even if they are not satisfied.⁵⁶ In situations like this, markets are ineffective at delivering quality care.

For those using local authority commissioned services, competition has not achieved its intended aims. Under constant budgetary pressures, local authorities are pushed towards a short-termist approach of purchasing care packages via competition between providers on the basis of price.⁵⁷ Since the biggest cost of providing care is staffing, this is where providers look to keep costs low and win contracts. Staff-to-client ratios are kept to a minimum, tasks and working practices are standardised and workforce pay and conditions are held down. The relationship between providers, commissioners, and those using services is rendered transactional. The quality of care suffers as a result.⁵⁸

It is also increasingly clear that local authorities are not able to undertake their market-shaping duty effectively. In her research on market-shaping, Catherine Needham found that local authorities have not been doing market-shaping in a purposeful way, but have been drifting between different approaches.⁵⁹ It has been estimated that more than half of local authorities have not updated their market position statements, which signal how they would like their local market to develop, since 2016.⁶⁰

Private companies have dominated in this environment. Social care is now provided by around 18,200 organisations in England, predominantly private, for-profit businesses. In the main they are small or medium-sized.⁶¹ But there has been a trend since the 1990s for smaller businesses to be bought out by chain companies, particularly in residential care.⁶² While chain companies only currently account for a quarter of the care home

market in the UK, and are less prominent in other forms of social care provision, given the major advantage of their easy access to capital, we can assume that their market share of residential care will increase in years to come.⁶³

These chain companies have shareholders that expect and receive, a 10%–12% rate of return on their capital.⁶⁴ To achieve this, they are known to have adopted cost-cutting practices at odds with care quality, such as reformatting the provision of care by building ‘Travelodge’ style homes with 60 to 70 beds and reducing staffing ratios.

Many of these chain companies are owned by private equity firms. HC-One, the biggest chain of residential care homes accounting for over 16,000 beds, was owned by private equity firm Terra Firma until it went bust in 2019, when it was acquired by US hedge fund H/2 Capital. The rise in private equity and hedge funds has seen an increase in the use of predatory financial techniques in the social care sector, such as leveraged buyouts and sale and leaseback arrangements, where a care home property is sold off and rented back to the social care company.⁶⁵ At the same time, they are using complex and opaque financial structures, involving offshore subsidiaries, to avoid paying corporation tax.⁶⁶

The financial practices of chain companies in residential care, combined with the low rates paid by local authorities and difficulties recruiting and retaining staff in both residential and domiciliary care mean that care markets are fragile. The Association of Directors of Adult Social Services’ Budget Survey 2019 found that 75% of councils reported that providers in their area had closed, ceased trading, or handed back contracts in the previous six months, with thousands of individuals affected as a consequence. Research has shown that when care homes are facing financial difficulties, care quality suffers: ‘The facilities deteriorate, staffing levels are reduced and additional “services” for residents, such as outings or entertainment, are cut back’.⁶⁷

The financial sustainability of social care markets is monitored, to a limited extent, by the Care Quality Commission (CQC). The regulator is required to assess the business health of the largest providers, who, if they were to fail, would be difficult to replace. The purpose is to give local authorities warning of likely failure so that they can put in place contingency plans. But their responsibilities do not extend to promoting financial resilience or even intervening to prevent financial collapse.

National responsibility for social care is split between the Department of Health and Social Care and the Ministry of Housing, Communities and Local Government, while the CQC regulates services. Skills for Care, a charity, acts as a delivery partner for workforce development, but there is no non-departmental public body responsible for the regulation and registration of the social care workforce in England. Despite its role,

the CQC's ability to drive improvement is very limited.⁶⁸ It is generally assumed that market forces will force poor performers out of the market,⁶⁹ but a residue of providers that fall below the required quality standard neither improve nor exit the market.⁷⁰ In their research on the CQC's impact on provider performance, the King's Fund notes the importance of fostering commitment, rather than compliance, to bring about improvement, tapping into providers' intrinsic motivation to do a good job and relying less on extrinsic motivation, which can descend into fear and risk aversion.⁷¹ But the market environment is designed to undermine this intrinsic motivation, making it difficult to engage providers in collaborative efforts to drive improvement. Providers do not tend to share learnings from inspections with each other, for example, because they are competing for business.⁷²

CRITERIA FOR REFORMING SOCIAL CARE

After decades of kicking the can down the road, the whole system is broken. Reform needs to deal with the multiple problems and their causes set out in the preceding sections, rather than one problem in isolation. Here, we argue that to fix these issues in the round, reforms need to meet two main criteria.

First, reform must close the funding gap or the difference between estimated income available to fund services and the cost of meeting all care needs through high-quality social care. Investment, however, needs to drive change in social care, not more of the same. So, secondly, reforms must close the implementation gap or the difference between the reality of social care provision and the vision set out in the Care Act's wellbeing principle.

CLOSING THE FUNDING GAP

The existence of a funding gap in social care is widely acknowledged. Its definition, however, is contested. We argue for a needs-based approach to defining the funding gap. In our view, the funding gap is the difference between the estimated income available to fund services and the cost of meeting all care needs through high-quality social care. Closing the funding gap requires a new funding settlement capable of the following three key policy reforms:

- *Making comprehensive social care free at the point of need by abolishing the means test.*

The balance of responsibility for social care funding between the individual and the state has been extensively debated in recent years. Evidence on public opinion shows a wide consensus in favour of a shift towards more responsibility for the state and less responsibility for the individual, with views split between people who think that the state should be responsible for paying for everything and others who think that individuals who can pay should be responsible for paying some of their costs.⁷³

Various policy proposals are aiming to achieve this shift. The cap and floor model, developed by the Dilnot Commission in 2011, and moderated in government proposals in 2021, both increases the generosity of the means test and places a limit on the amount that individuals might have to pay for social care. Free personal care, which has been provided to people over the age of 65 in Scotland since 2002 and was extended to those under the age of 65 in 2019, makes support with a specified set of tasks free at the point of need. It has succeeded in improving access to personal care services in Scotland,

but it has also led to a reduction in access to other social care services.⁷⁴ Even if enough funding were provided to avoid situations where non-personal care services are cut in favour of personal care services, the policy would be limited in the extent to which it makes all forms of social care universally available.

We argue that the state should be fully responsible for social care funding and ensuring that comprehensive care is free at the point of use for the individual. The uncertainty inherent in the risk of needing care makes it difficult for individuals to anticipate if and when they will need care, how extensive and long-lasting their care needs might be, and what kinds of support they might be able to draw on.⁷⁵ Any model in which people have to pay for their own care means that many will go without the care they need to avoid paying its costs. Such a model will also continue to rely on family, especially women, providing informal and unpaid care, unsupported by wider social and economic policy. Pooling this risk through the state by ensuring that care needs are met is an effective way to protect the population from it. It is arguably the fairest approach to funding social care; the costs of needing care should not lie where they happen to fall but should be spread equitably across society.

Two objections are often raised to this approach. The first is that the cost to the state is unsustainably high. We address this in the final chapter of this report. The second is that making social care free at the point of need, like the NHS, would disproportionately benefit the better off compared with the current situation. In our view, this misses the point: any widening of access to publicly funded support from the current stringent means-tested system would broaden the provision of public care to those who are less poor. In any case, as we argue in the final chapter, the costs can be met progressively, through taxation.

- *Widening the availability of social care by ensuring the fair application of national eligibility criteria.*

Abolishing the means test on its own, however, will not resolve unmet needs if eligibility criteria are set unreasonably high, or they are unfairly and inconsistently applied. Efforts to close the funding gap must also ensure there is more public money in the social care system to expand eligibility for support so that it is based on a fairer assessment of need, consistently applied across the country.

Neither cap and floor proposals, nor proposals for free personal care, on their own, account for the need to widen eligibility for care.

- *Improve care quality and working conditions by introducing a higher sector minimum wage.*

A new funding settlement aimed at closing the funding gap must also ensure that there is enough money to improve care quality, training, pay, and conditions. To improve care quality, there must be better training and higher levels of qualification. The nature of this training should also change so that, in line with the wellbeing principle of the Care Act, it equips the care workforce with the skills to support people to achieve what they want to in life. Wages should increase in line with higher qualifications. We view the rise in pay as an essential part of a high-quality universal care system in which care work is seen as a valued career with job security and progression opportunities.

Once again, neither cap-and-floor proposals nor proposals for free personal care, on their own, account for the need to improve care quality and working conditions.

CLOSING THE IMPLEMENTATION GAP

The Care Act 2014 introduced wellbeing as a guiding principle for social care. It defined wellbeing in an intentionally broad way, distinguishing physical, mental, emotional, social, and economic dimensions of wellbeing, and deeming them to be of equal importance. It required local authorities to consider how to meet every person's specific needs, instead of fitting them into a generic set of services. The purpose of social care became 'help[ing] people to achieve the outcomes that matter to them in their life'.⁷⁶

What this could mean in practice is captured very nicely by a quote from Social Care Futures: 'We all want to live in the place we call home with the people and things that we love, in communities where we look out for one another, doing things that matter to us.'⁷⁷ The job of the social care system is to support people to achieve these things. It is a vehicle to enable people to do what they have reason to value.⁷⁸

The wellbeing principle sets out an admirable ambition for care, with similarities to calls for independent living — for years advocated by the disability rights movement — whereby 'all disabled people have equal rights to live in the community, with choices equal to others, and be fully included and able to participate in the community'⁷⁹. The act signified a promising change in approach away from the life and limb care that has dominated since the establishment of the welfare state. The problem, however, was that the reality came nowhere near the aspiration. The resources needed to put this into practice were never allocated and the system was not set up to deliver it.

This is what we mean by the implementation gap, or the difference between the reality of social care provision and the vision set out in the Care Act's wellbeing principle.

The two main reform proposals on offer do not meet the implementation gap criteria. A Dilnot cap on care costs, on its own, will do little to shift the system towards wellbeing.

Rather, it aims to ensure that people do not have to pay catastrophic costs to access the current care system. Free personal care, while a progressive policy that would provide people with a universal entitlement to some essential support, is too restrictive and too prescriptive. Proposals for free personal care seem to be focused only on the basics of survival and physical functioning. And they do so by defining, from above, the tasks that social care should deliver. By setting tasks to be delivered, it leaves little room for the autonomy of either caregiver or those supported. Universalism must not mean uniformity. Social care should be made up of diverse services, shaped with the people who use them.

Closing the implementation gap requires a major change in local authority practice. Local authorities should be seeking to transform social care provision in line with the wellbeing principle, working collaboratively with people needing support and their families, and with providers that genuinely share their aims.

There are, however, two main areas in which more and better intervention from central government is needed. The first is setting and enforcing standards. Local variation in the provision of social care should be a positive response to local priorities and local assets, not the result of inconsistencies in availability or quality. People needing support should be able to expect the same high standards of care, and social care workers should be able to expect the same high standards of working conditions, no matter where they live. The second is supporting the sharing and spreading of good local practices between places.

PROPOSALS FOR A UNIVERSAL QUALITY SOCIAL CARE SERVICE

To close the funding and implementation gap, we propose three broad policy solutions: a generous new funding settlement, an expanded role for local authorities, and a new national body to drive improvement.

A NEW FUNDING SETTLEMENT

Estimating the cost

Inevitably, costing a reformed and expanded social care system requires making a series of assumptions, including about the level of need taken as the threshold for entitlement, the average number of hours of care needed to meet the need, the pay and conditions of care workers, and the take-up rate of care for those who are entitled to it.

To estimate the level of demand for care under a more generous system, we use the Care Act definition of the minimum eligibility criteria for local authority care. According to this definition, three conditions must be met for a person to have an eligible need for publicly funded social care support: (a) a need arising from a physical or mental impairment or illness; (b) an inability to achieve two or more specified outcomes; and (c) an impact on wellbeing as a result. Using data from the Family Resources Survey and the Health Survey for England, we have estimated that 17% of those aged over 65 and 2% of those aged between 18 and 64 would have eligibility needs under this definition in a given year.

To estimate the number of hours per week needed to provide adequate care to meet these needs, we have used two different methods. For domiciliary care services, we have used information about average hours of formal care provision commissioned by local authorities in England (12 hours for those aged over 65 and 21 hours for those aged 18–64). For residential care, we used 24 hours of care a week based on current ratios of staff to residents, excluding hotel costs. We have also included an allowance for overheads and modelled raising minimum pay to the Real Living Wage, a rate designed to be sufficient to meet what members of the public consider to be everyday needs.

Finally, we have also tested the sensitivities of our costing to different levels of take-up. For those aged over 65, we model four illustrative scenarios for take-up: 30% of those eligible gives our lower bound for take-up in line with the current system in England; 39% take-up is based on the levels of take-up seen in Scotland under free personal care;

a 68% take-up scenario is based on the assumption that everyone eligible, except those who receive informal care between 1 and 19 hours, takes up care; and finally we model 100% take-up of those eligible as a conceptual upper bound. In reality, take-up under a universal care system is highly uncertain, with the only certainty being that it is likely to fall between the levels seen under free personal care in Scotland and the 100% upper bound. Given this uncertainty, we take a 68% rate as our core scenario for take-up among those aged over 65. For the under 65s, we assume 65% take-up for all scenarios other than our conceptual upper bound, based on the assumption that means-testing has little effect on current take-up among working-age adults. For more information, including the assumptions underpinning our modelling, see the appendix to this report.

Table 1 presents the costings for three different counterfactual scenarios for a universal care service in 2021/22 terms, without a pay increase, with an increase in the minimum pay listed to the level of the Real Living Wage and with an increase in training and pay in line with Nordic levels. In reality, our proposals would take a parliament or more to implement, but this exercise enables a comparison on a like-for-like basis with today's system, in today's economy, at today's prices. In our core scenario for take-up, the additional cost of care under a universal system would be £19.6bn per year, on top of the £20bn cost of the current system before care caps introduced as part of the Health and Social Care Levy have been introduced. Simultaneously raising the rate of pay to the Real Living Wage would require another £12.3bn. This should be the immediate priority.

Table 1. Costs for universal care under different levels of minimum pay and different take-up rates (England - £m), 2021/22

| Scenarios | Total cost | Take-up rates for Under 65s / Over 65s | | | |
|---|------------|--|-----------|-----------|-------------|
| | | 65% / 30% | 65% / 39% | 65% / 68% | 100% / 100% |
| additional cost compared to baseline | | | | | |
| Baseline - current system | 20,100 | - | - | - | - |
| Universal care, current pay | - | 10,700 | 11,900 | 19,600 | 33,300 |
| Universal care, real living wage | - | 19,800 | 21,500 | 31,900 | 50,500 |
| Universal care, higher training and wages | - | 33,600 | 36,000 | 50,400 | 76,300 |

Source: Own calculations. Figures in 2021/22 prices and rounded to the nearest £100m

Beyond this immediate priority, a transformative care system would extend services to a wider group with moderate care needs while increasing the quality of care through higher levels of training and skills. This in turn would require higher wages, bringing the pay of care workers in the UK more in line with that of Nordic countries at around 75% of nurses' wages.

Our proposals are therefore more expensive than many other, more incremental reforms currently mooted in the debate (see the appendix). However, they are intended to address the range of problems facing social care. Rather than presenting them in a piecemeal manner, designed to address one issue in isolation, we have combined costs to assess how much it will need to deal with the issues in the round. What's more, total social care spending would remain a relatively small fraction of health spending, which in 2019/20, before the pandemic, totalled more than £150bn.⁸⁰

Raising the revenue

A transformation in the social care system requires a transformative funding settlement. This settlement also needs to come centrally. The increasing reliance of local authorities on local sources of revenue over the past decade has particularly disadvantaged deprived areas with a lower tax base and higher levels of need for publicly funded social care. It runs counter to policies aiming to pool risks and provide more consistency in the availability and quality of provision across the country. Responsibility for *funding* social care, but not organising and delivering it, should, for these reasons, be transferred from local to central government. This should include both generating and allocating resources, ensuring local allocations are proportionate to local needs.

The recovery from Covid-19 represents a near-unique opportunity for an expansive funding settlement for care. The wider economic recovery in the UK remains weak, with the Office for Budget Responsibility estimating that aggregate incomes are likely to remain 2 percentage points below their pre-pandemic trend in perpetuity.⁸¹ This contrasts with the USA, where off the back of a general stimulus worth 9% of GDP, forecasters expect incomes to fully recover levels implied by the pre-Covid trends.⁸² A stimulus on a similar scale in the UK would have required a £50bn to £70bn on top of the additional spending announced at the 2021 Budget and Spending Review.⁸³ This suggests that there is ample room for debt-financed stimulus in the UK economy that could be used to help establish a universal care system in the near to medium term. For example, our modelling suggests that the additional investment required for our core scenario would generate 928,000 new full-time-equivalent jobs in 2021/22 terms, both in

the care sector and more widely through indirect and induced employment, boosting tax receipts by £14bn.

However, in the longer term, and as the economy returns to its full potential, it is likely that at least some of the public funding for a universal care service would need to be offset by expanding the tax base elsewhere in the economy (some will continue to be paid for by additional tax receipts). We argue that closing this ‘tax gap’ should focus on wealth – both through higher taxation on concentrations of wealth themselves (eg through the reform of inheritance tax) and through bringing the taxation of income from wealth (eg dividends and capital gains) into line with earnings from employment.

There is a range of options capable of expanding the tax share at the scale required to deliver the funding settlement required, while leaning into undertaxed sources of wealth and income in particular. For example, modelling at the University of Warwick has shown that alternative reforms to national insurance from the government’s recent policy – including removing the exemption for investment income, removing the exemption for pension-age individuals, and equalising the rate of tax for high earners with that of lower earners – could raise more than £31bn a year in 2021/22 terms. This alone would be sufficient to finance our core scenario with an uplift in minimum pay to the Real Living Wage (Table 1).

A similar level of funding could also be delivered through an alternative basket of tax reforms. For example, closing gaps and loopholes in inheritance tax has been estimated to raise more than £7bn per year⁸⁴ and reducing the rate of tax relief on pension contributions for high earners to the same level of relief seen by basic rate taxpayers could raise a further £8bn.⁸⁵ Equalising the rate of tax on dividend income tax with income tax on earnings by removing additional allowances and increasing the headline rate has been estimated to raise £8bn after downward revisions for behavioural effects.⁸⁶ Similar reforms to capital gains tax are estimated to raise at least £12bn per year after behavioural effects.⁸⁷ Combined, these reforms could be expected to raise at least £35bn per year in total.

In the coming years, any system of social care will be set to come under increased cost pressure as a result of the UK’s ageing population. Having established an initial funding settlement rebalancing the tax share between wealth and earnings, future tax increases required to meet demand could more easily be broadly shared across earnings, wealth, and consumption.

AN INCREASED ROLE FOR LOCAL AUTHORITIES

The expansion of publicly funded social care would enable an increased role for local authorities in the organisation of social care provision. This would bring a significant opportunity to intervene, to transform provision in line with the wellbeing principle in the Care Act.

We propose that local authorities, working with people needing support and their families, should be required to develop and deliver long-term strategies to achieve this aim. If it is to close the implementation gap and support wellbeing, social care should be made up of diverse services, shaped with the people who use them. This means putting the principle of co-production at the centre of social care, where people using services and those providing them work together in equal and reciprocal partnership, pooling their diverse knowledge and skills.

In our view, two broad functions are required. While people should continue to have the option of receiving a direct payment or a personal budget, this should be combined with more and better collective services, designed and delivered in a way that distributes control. To get there, we suggest that two major changes are needed.

First, shifting the organisational nature of provider organisations receiving public money away from for-profit towards providers that are (1) legally bound to follow a clear social mission and (2) accountable to people needing support. This means supporting non-profit models from the voluntary and community sector, including cooperative, disability-led organisations and community-based providers. It also means a much more significant role for local authorities, as public bodies that are democratically accountable to their local communities. Those that develop a culture of working in co-productive ways will be well placed to provide more care.

However, even democratic provider organisations will find themselves having to act like private companies when commissioned in a competitive market. So there will also need to be a step-change in the relationship with and between the local state and provider organisations. Rather than short-termist, cost-driven competitive tendering, local authorities should move towards collaboration and strategic partnership in pursuit of shared goals. Through public-social partnerships, local authorities would shift to a trusted partner system, able to give – and terminate – long-term grants to socially minded, accountable providers. Importantly, the commissioning process would be opened up to people needing support and their families, and it would be used to ensure providers design and deliver services with those intended to benefit from them.

As Bob Hudson argues, however, the privatisation and marketisation process has gone unchecked for so long that ‘there is now no feasible prospect of simple and total reversal.’⁸⁸ Repealing these processes should be the goal, but change will need to be gradual. It should begin with:

- Local authorities buying out providers that are either failing or consistently providing poor quality care, in order to run them or hand them over to more suitable care providers.
- Commissioning care using a form of ethical care charter or preferred provider strategy, which would favour providers that meet certain criteria, such as those that pay sufficient wages without zero-hours contracts and those that are accountable to those needing support.

Over time, local authorities should:

- Direct a growing share of their increased funding settlement each year to the public sector, and co-operative and community-based providers while supporting their capacity and the number of these providers to grow.

A NEW NATIONAL BODY TO DRIVE IMPROVEMENT

The expansion of publicly funded social care would make the need for more consistency in the availability and quality of social care provision even more pressing than it already is. The government’s recent White Paper on health and social care proposes a new duty for the CQC to assess local authorities’ delivery of their social care duties and a new power for the Secretary of State to intervene where it is considered that a local authority is failing to meet their duties.⁸⁹ This has been criticised, however, on the grounds that it risks punishing local authorities for failing to meet duties they lack the resources to fulfil.⁹⁰ Meanwhile, the independent review of social care in Scotland, chaired by Derek Feeley, recommends the establishment of a National Care Service, on an equal footing with NHS Scotland, with both bodies reporting to Scottish ministers. The National Care Service would oversee local services, with a driving focus on improvements in consistency, quality and equity of support.

We propose a similar approach in England, with the creation of a new national body that would work with local authorities to transform social care provision. It would set and enforce high standards for both care quality and job quality and share and spread good local practice. The CQC should sit under it, though we argue that its role should first be reviewed to determine if it is fit for purpose. A new agency with responsibility for the regulation of social care workers should be set up to sit under it as well. As

recommended in Scotland, this body should have representation from people needing support, unpaid carers, social care workers, and providers.

CONCLUSION

To build a more caring society post-Covid, social care needs to be reformed in the round. That means closing the funding gap so that the cost of meeting all care needs through high-quality care is covered alongside a well-trained workforce with decent pay and conditions. And it will mean closing the implementation gap so that the reality of social care meets the aspirations of the wellbeing principle of the Care Act. It will need a generous new funding settlement, an expanded role for local authorities, and a new national body to drive improvement. A social care system like this would be transformative for those immediately affected but also for society as a whole. It would provide the security of knowing that if we, or someone we care about, has a disability or health condition during our lives, we would have the support we need.

ENDNOTES

The appendix for this report is available at neweconomics.org/uqsc

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