Commission on a Gender-Equal Economy

PAPER 6

Social care and gender equality

Marion Sharples[1], November 2019

This is a preliminary paper on social care to inform the Commission's discussions on public services in Belfast. It will be expanded after the planned roundtable on social care which will take place in early 2020. The paper draws primarily on three resources (the Women's Budget Group 2018 briefing on social care[2], the report of the Political Studies Association Commission on Care (2016)[3], and Sue Himmelweit's 2018 article on Transforming Care[4]), all of which focus on England. As a result, this paper mainly focuses on England. The paper will be expanded to include the other 3 nations of the UK over the course of the Commission.

Disclaimer: This paper was written by a Women's Budget Group staff member to inform the Commission on a Gender-Equal Economy and should not be taken to represent the views of the Commission on a Gender-Equal Economy.

Receiving and providing additional support in order to lead fulfilled lives are essential parts of human existence. The majority of adults who need care in older age and/or as a result of disabilities and illnesses are women; the majority of those who provide care are women; and the majority of those who are responsible for organising care for family members are women. Some adult care has moved into the paid economy in recent decades.[5] Still, 6.5 million people in the UK, the majority of whom are women, care unpaid for adult family or friends.[6]

While this paper focuses mainly on domiciliary support, both paid and unpaid, and residential care, it's important to note that care takes a huge variety of forms. As well as domiciliary support and residential care, care encompasses crisis care, respite care, as well as provision of services within the community, such as day care centres and community wellbeing activities.

This paper provides an overview of:

1. The current social care system in the UK and its shortfalls
2. What a social care system in a gender-equal economy would look like, and how it would be provided
3. Key recommendations on how to bring about this social care system

[1] With much support from Sue Himmelweit and Ruth Pearson
[2] WBG 2018 social care briefing https://wbg.org.uk/wp-content/uploads/2018/10/Social-Care-October-2018-w-cover.pdf
[3] PSA Commission on Care (2016). Towards a new deal for care and carers http://www.commissiononcare.org/wp-content/uploads/2016/10/Web-Care-Comission-Towards-a-new-deal-for-care-and-carers-v1.0.pdf
[4] Transforming care, Susan Himmelweit, in Laurie Macfarlane (ed), New Thinking for the British-Economy, Open Democracy, 2018 https://www.opendemocracy.net/laurie-macfarlane/new-thinking-for-the-british-economy
[5] Transforming care, Susan Himmelweit, in Laurie Macfarlane (ed), New Thinking for the British-Economy, Open Democracy, 2018 https://www.opendemocracy.net/laurie-macfarlane/new-thinking-for-the-british-economy
[6] Carers UK written evidence to House of Lords, 2018 http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/economic-affairs-committee/social-care-funding-in-england/written/91445.html

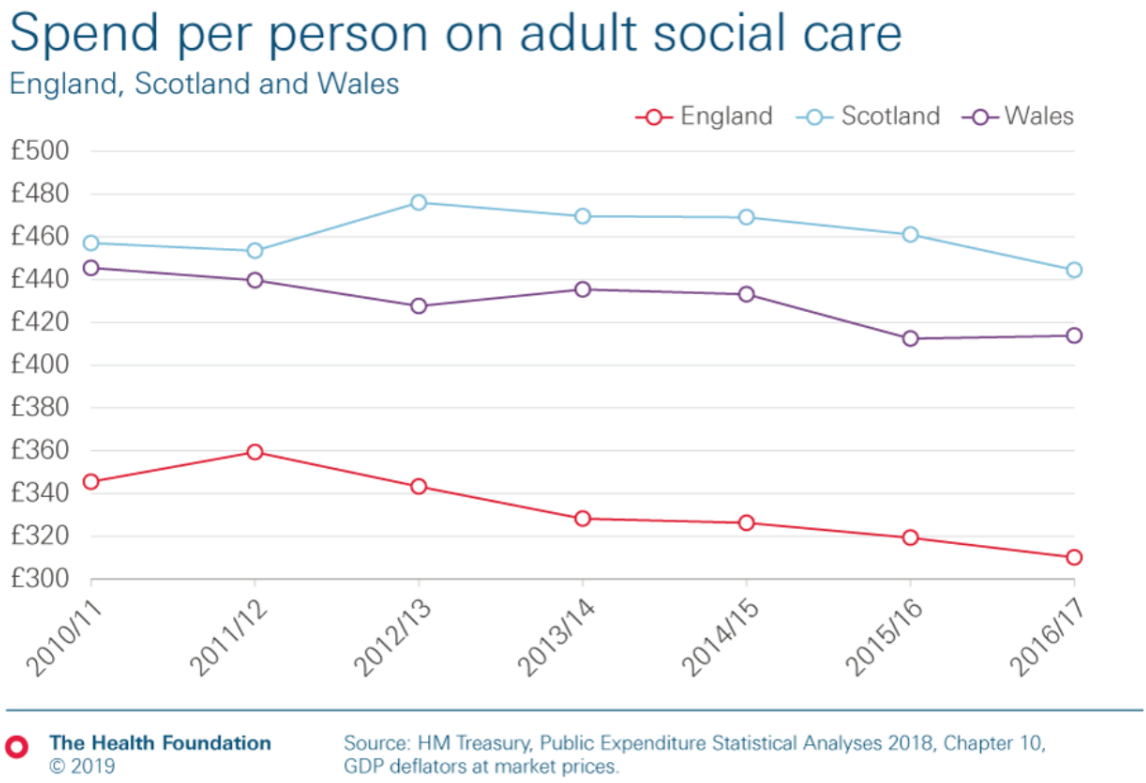
1. The current social care system

Unlike the health care provided by the National Health Service, "social" care is not generally free at the point of use across the UK. While provision and funding varies across the four nations of the UK, determining whether a person is eligible for any help with their care, whether free or subsidised, is done by the local authority (or Health and Social Care Trust in Northern Ireland).

This section details different aspects of the current social care system.

Funding

The supply of state-funded care is decreasing, while the demand for care is increasing. This is what has led many to recognise the current situation as a crisis. Since 2010, local authorities across all parts of the UK have had their income from central government slashed, and spending on adult social care has fallen too (see chart below for the pattern in England, Scotland and Wales).



Even just to return to the levels of provision in 2009/10, when social care was already widely seen as underfunded, spending in 2017/8 would have had to increase from £17.9bn to £24.3bn, a rise of 36%. To get to this level of provision in 2021/22 would require spending to rise to £27bn, and to £38.7bn by 2030/31, in today's prices, a funding gap of £8bn and £15bn respectively.[7]

[7] Watt, T. Varrow, M. Roberts, A. and Charlesworth., A. (2018) Social care funding options: How much and where from? https://bit.ly/2EtdNwn , in WBG 2018 social care briefing

Across the UK, the number of people who are able to access help with their care is falling, leading to a growing population of people with unmet care needs. Due to government-imposed fiscal constraints, only people with the most severe and acute care needs are qualifying for any support.[8]

The government's plans for local authorities to depend less on funding from central government and more on local business rates will result in large disparities between richer and poorer areas. This may result in the poorest local authorities having to charge the highest rates of council tax (if they are allowed to), even though their residents are least likely to be able to afford this.[9]

The appropriate mode of financing social care is deeply contested politically, with a range of models of co-financing between the state and the individual being put forward by different experts and stakeholders.[10] Accordingly, there has been an ongoing debate within successive governments in Westminster about the financing of care – not just in terms of national funding versus local authority funding, but also the question of an individual's contribution to care costs. The current state of play differs across the UK: in Scotland, personal care (help washing and dressing or preparing meals but not housework, laundry or shopping) is available free of charge to over-65s and all adults with disabilities or degenerative conditions, regardless of income and personal assets. In England and Northern Ireland, only those with assets of less than £23,250 receive support from the state to meet their costs at the moment (except the over-75s with acute needs in Northern Ireland, who are entitled to free personal care). In Wales, this asset limit is £24,000, but the cost of home care that an individual pays is capped (currently, at £90 per week).

Unmet needs

The current social care system is a flawed, inflexible, and vastly underfunded patchwork of services, which is a far cry from a supportive, personalised system which increases people's capabilities, sense of self, and ability to flourish as humans and community members.

Even when we lower the bar, however, and judge the care system against the lower objective of providing people with the most basic care needed to get from day to day, it scores extremely badly. In 2018, Age UK found that the number of older people who don't get the care and support they need to carry out 'activities of daily living' such as getting out of bed, going to the toilet, washing and getting dressed, rose to a record high of 1.4 million. This is an increase of almost 20 per cent in two years.[11]

The PSA Commission on Care found that care recipients 'often do not get what they need – and yet must be grateful for what they do get', given that there are so many people in need of care who do not receive any support at all. Further, care services have often failed to respond appropriately to people of ethnic minorities in need of care, for example failing to take into consideration that Black, Asian and Minority Ethnic people are less likely speak English as a first language, and are less likely to have the savings or inherited wealth needed to cover care costs. Similar failings were observed were made with regard to older LGBTQI people. [12]

[8] PSA Care Commission
[9] Communities and Local Government Select Committee (March 2017) *Adult Social Care* (http://bit.ly/2jsjaCa) (p.1), in WBG 2018 Social Care briefing
[10] House of Commons Library, Briefing Paper No CBP07903, 3 October 2019
[11] https://www.ageuk.org.uk/latest-press/articles/2018/july-2018/new-analysis-shows-number-of-older-people-with-unmet-care-needs-soars-to-record-high/
[12] PSA Care Commission

In residential care, the picture is no better: In 2017, an ADSS survey of 105 English councils showed that over half of councils had found it difficult or very difficult to get a place in a nursing home, a fifth had found it difficult or very difficult to get a place in a residential home and 46% had struggled to get homecare. Nearly two-thirds had experienced provider closure and 90% had quality concerns.[13] Why is this? Many residential care providers claim they cannot provide places for the amount they are paid per resident, and have to cross-subsidise from people paying their own fees (which is generally only possible in more affluent areas). However, others claim that care providers are 'milking the market', demanding high returns for a business that is very low-risk.[14] Indeed, many care homes are owned by hedge funds that extract a large profit indirectly through fees and rents paid to other companies under the same ownership.[15]

The marketisation of care provision

Most social care is now provided through the private sector, and people either pay for care directly, or local authorities pay the private providers on behalf of the care recipient, if they qualify for state support. The private sector model is supposed to increase consumer choice, and through competition, increase quality of service provision and keep costs low. But in many cases, these conditions for consumer sovereignty are often not met, because care is not the sort of good for which market provision works. Firstly, because continuity of care is important, particularly in residential care, people are less likely to switch providers often, which means the motive for care providers to keep quality high is reduced.[16] Secondly, information about care options is hard to obtain – not least because decisions about care are often made at short notice and under pressure: 'the same frailty and dependence that creates the need for care may limit consumer sovereignty'.[17] Further, because a key element of care is its relational quality, it is hard to assess the quality of care provided without experiencing it, so there is only so much knowledge that can be gained from pre-care 'information'.

Thirdly, in terms of keeping costs low, because most of the costs of care provision comprise staff wages, so competition only lowers costs if staff numbers are cut, or less well-trained or well-qualified staff are employed – both of which tend to reduce quality. For example, because of this pressure to keep staff costs low, domiciliary care workers are under pressure to be as 'productive' as possible by maximising the number of care recipients they support. This means they are unable to fully engage with the relational aspect of their work, instead rushing from brief appointment to brief appointment (often at their own cost – travel between appointments is frequently not covered by employers) and being forced to focus on the most 'quantifiable' part of their job, e.g. ensuring a person is washed/dressed/has taken medication.

Finally, the care system is extremely complex, often with multiple layers of procedures, such as needs assessments, means-testing, weighing up residential care versus home care, the distinctions between home care and home help, and so on. Navigating the system places a high administrative

[13] ADASS (2017) *Autumn Short Survey of Directors of Adult Social Services* (http://bit.ly/2mvr4vL)
[14] CRESC Public Interest Report (2016). Where does the money go? Financialised chains and the crisis in residential care http://hummedia.manchester.ac.uk/institutes/cresc/research/WDTMG%20FINAL%20-01-3-2016.pdf
[15] https://www.theguardian.com/society/2019/nov/07/care-home-operators-accused-of-extracting-disguised-profits
[16] Brennan et al. (2012). The marketisation of care: Rationales and consequences in Nordic and liberal care regimes. Journal of European Social Policy 22(4): 379.
[17] Eika, K. (2009) 'The Challenge of Obtaining Quality Care: Limited Consumer Sovereignty in Human Services', Feminist Economics 15(1): 113–37, in Brennan et al. (2012). The marketisation of care: Rationales and consequences in Nordic and liberal care regimes. Journal of European Social Policy 22(4): 379.

burden on recipients of care and their carers, and so those with greater resources and education are able to better make informed decisions about care provision.[18]

Unpaid carers

An inadequate social care system has a huge impact on unpaid carers too (who, as mentioned above, are disproportionately women). Reduced social care services, combined with reduced support for unpaid carers and cuts to other local authority services such as lunch clubs and libraries (which provide information, peer support, and respite), means that unpaid carers are faced with a 'triple jeopardy.'[19]

Further, if people (mainly women) have to drop out of the labour market to fill the gaps in state-provided care, they also reduce their ability to earn and save for their own care in later life. Carers UK found that over 2.6 million people have given up work at some point to care for loved ones, 2 million have reduced their working hours, and half of carers cited problems with accessing suitable care services as a reason they gave up work or reduced working hours.[20]

Paid care workers

Care workers are faced with low pay, poor working conditions and negligible career prospects. In 2016 in England, a third of domiciliary care workers had no training in dementia care and a quarter of domiciliary care workers had no training in the administration of medication.[21] The story is similar in care homes: one residential care worker described in a media interview in 2017 how the work was "stressful" and that she got "very little training", adding that because of the low pay and long hours, some people "cut corners".[22] High vacancy rates, and retention issues are widespread, with 48% of care workers leaving within a year of starting. [23] The Communities and Local Government Select Committee reported 'severe challenges in the social care workforce', citing 'low pay not reflecting the amount or importance of the work involved, low status, poor terms and conditions, and lack of training opportunities and career progression' as the roots of the problem. [24]These include:

- the median hourly pay for a care worker is £7.40;
- 160,000 to 220,000 care workers in England are paid below the national minimum wage
- 49% of home care workers are on zero-hours contracts, compared with 2.9% of the workforce nationally[25]

Who is doing these roles? As well as being the majority of unpaid carers and care recipients, the majority of the care workforce are women. There is also a high proportion of migrant workers in the care workforce, particularly within lower-paid roles, as well as universal credit claimants referred to

[18] Eika, K. (2006) 'The Difficult Quality: Essays on Human Services with Limited Consumer Sovereignty', PhD thesis. Oslo: Department of Economics, University of Oslo, in Brennan et al. (2012). The marketisation of care: Rationales and consequences in Nordic and liberal care regimes. Journal of European Social Policy 22(4): 379.
[19] PSA Commission
[20] https://www.carersuk.org/images/Facts_about_Carers_2019.pdf
[21] Skills for Care (2018). The state of the adult social care sector and workforce in England 2018, quoted in WBG 2018 Social Care briefing
[22] Independent (2017). Nearly half UK care home workers leave within a year, finds report https://www.independent.co.uk/news/uk/home-news/care-home-workers-half-leave-jobs-within-year-staffing-levels-problem-report-communities-and-local-a7658281.html
[23] Communities and Local Government Select Committee (March 2017) Adult Social Care (http://bit.ly/2jsjaCa)
[24] Communities and Local Government Select Committee (March 2017) Adult Social Care (http://bit.ly/2jsjaCa), quoted in WBG 2018 Social Care briefing
[25] Communities and Local Government Select Committee (March 2017) Adult Social Care (http://bit.ly/2jsjaCa)

care employment vacancies. If migration flows are stemmed following Brexit, recruitment and retention within the care sector will become even harder.

The lack of a commitment to meeting everybody's care needs in public policy is striking. While many people with care needs are forced to rely on unpaid care (mainly performed by women, as discussed previously), many people with care needs simply find their needs are not met at all. 30% of older people in England with care needs receive little or no help, 37.5% receive unpaid care from family or friends, 21% receive local authority support and 21.5% pay for care themselves.[26] This lack of political commitment to meeting everyone's needs, combined with the reality that there *are* people (most often marginalised people, including migrants) prepared to take care jobs despite such poor pay and conditions, mean that the current situation lurches on. However, the recruitment and retention crisis, as outlined above, particularly in the light of Brexit, means that we cannot rely on the supply of people prepared to do care work under such conditions.

Knock-on effects on other public services

The insufficient nature of the care system means that other services, particularly the NHS, are put under extra strain. The lack of a functioning social care system results in preventable hospital admissions, increased A&E traffic, and patients unable to be discharged from hospital even when they no longer require medical treatment, because they don't have the support to go home.[27]

Research by Age UK in 2018 showed that these 'delayed discharges', due to a lack of adequate social care, cost the NHS £550 per minute (£290 million a year). [28]

Lack of political will

Given that things are so bad, why have things not changed? Theresa May's 'cap and floor' proposals were received very poorly by the public, dubbed the 'dementia tax', and quickly abandoned. Boris Johnson has pledged to 'fix the crisis in social care once and for all', but there has been no sign of any proposals emerging yet – although this may well change soon after the time of writing, when manifesto pledges ahead of the December 2019 general election are announced.[29] Indeed, the crisis in social care, most acute in England and Wales, is not a new phenomenon – so how have we got to this point? Why hasn't it been sorted yet?

The PSA Commission on Care put forward four reasons for the lack of progress on social care:

1. **Too big to tackle.** Providing good quality care for all who need it is seen as expensive. Indeed, the estimated £7bn per year it would cost to introduce a universal free personal care system across the UK is not a negligible amount, but as Helen Buckingham, the director of strategy at the Nuffield Trust thinktank, argues, this £7bn a year is a fraction of the NHS budget, which is due to hit £148.5bn by 2023-24.[30]

2. **Someone will step in**. The assumption is that if the state doesn't provide support, needs will be picked up and covered as best they can by someone who is not a paid carer (most often a woman).

[26] https://www.bbc.co.uk/news/health-49796898
[27] PSA Commission
[28] https://www.ageuk.org.uk/latest-press/articles/2018/july-2018/new-analysis-shows-number-of-older-people-with-unmet-care-needs-soars-to-record-high/
[29] https://www.theguardian.com/uk-news/2019/aug/01/promising-to-fix-social-care-could-cost-boris-johnson-dearly
[30] https://www.theguardian.com/uk-news/2019/aug/01/promising-to-fix-social-care-could-cost-boris-johnson-dearly

3. **Older people's and carers' lives are not valued**. There is a lack of concern about, and value placed on, the lives of older people and carers.

4. **Anyone can care**. Because it's assumed that 'anyone can care', means that caring is regarded as low status and unskilled work, which doesn't require training, professional development, or career progression.

2. Building a gender-equal economy: a new care system

It's clear that a new approach is desperately needed. Sue Himmelweit outlines principles on which a new social care system should be based.[31] A social care system should:

- **Redefine its mission** in positive terms: to enable everyone to be able to choose to do, as far as possible, what others can do unaided.
- **Invest the resources necessary** to provide the care infrastructure to fulfil that mission both now and in the future.
- **Create good working conditions**, professional standards and a public service ethos in the care profession, so that both men and women are proud to work in it.
- **Enable unpaid care** to be freely given, without limiting other opportunities for those providing it or putting unfair demands on particular individuals to do so.
- **Enable democratic**, not just market, **choice** of the forms of care to invest in for the future.

3. Recommendations

The UK government should:

- **Establish a National Care Service** on equal footing to the NHS, funded by general taxation. This service would guarantee the provision of care to all those whose capabilities are currently restricted. The service would be free at the point of delivery, and ensure that everyday care, as well as crisis care, was provided. It would be a publicly guaranteed and provided service, which would make use of the best of local non-profit organisations' innovation and expertise.
- **Develop** minimum, enforced **standards** coupled with a diversity of provision
- **Incorporate the voices** of care recipients and providers into policy-making and the shaping of services through a co-production model
- **Invest in the social care workforce, treating this as part of social infrastructure,** matching resources to needs (with an awareness that these are locality-based and will be constantly changing), and **reform the national accounting system** so that this spending is recorded as investment (as opposed to being recorded as current expenditure)
- **Professionalise the care workforce**, improving its status, the working conditions and pay in paid care, and implementing training programmes and developing career paths, so that care workers are proud to be care workers
- **Increase support for unpaid carers, on the assumption that the norm for workers is to have some care responsibilities**, acknowledging that paid care will always work in tandem

[31] Transforming Care

with the care that families and friends provide. This includes: enforcing working time regulation, paid carers' leave, and flexible working.

- **Mainstream care into all policy making,** so that the implications of all policies for those who need and provide care is taken into account. In particular, planning and housing policy should be developed with a view to creating a seamless range of ways on which people can receive care over the life course, breaking down the dichotomy between residential and domiciliary care.