Fixing the Care Crisis

By Damian Green MP

About the Author

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Contents

How to Fix Social Care

1. Britain's current social care arrangements are financially and politically unsustainable, as well as opaque and unfair.
2. Problems in social care have a huge knock-on effect on the health service. The success of the NHS funding plan depends on developing a better social care system.
3. This report proposes adopting a "state pension model" by introducing a new Universal Care Entitlement, which guarantees everyone a decent standard of care.
4. People could pay for more expensive care on top of the Universal Care Entitlement by purchasing a Care Supplement.
5. Funding would shift from councils to Whitehall, easing pressure on local budgets and encouraging the approval of more retirement housing and care homes.
6. These proposals would be fair, fully funded, and prevent both the "dementia lottery" and people being forced to sell their homes.

Introduction

The issue of how to provide social care for older people has troubled governments of all parties for nearly two decades.

So far, political difficulties have prevented the emergence of any solution that looks stable in the long term. Commissions and reports have come and gone, Select Committees have investigated and made recommendations, and we are no closer to a political consensus on how to proceed.

The General Election of 2017 summed up the perils of grasping this particular nettle. A Conservative Party promise to allow people to keep £100,000 of assets whatever the costs of care – actually more generous than the system it replaced – was rapidly dubbed a "dementia tax". The Labour Party had a similarly bruising experience in 2010, when its own proposals were attacked as a "death tax".

The situation is urgent – and will only get more serious in the decades ahead. There are 5.3 million over-75s today. That number will double over the next 40 years. And those people will not just be living longer, but will have more complex and expensive care needs.

All agree that there will be an enormous increase in demand for social care, and that the current system will be unable to cope. Indeed, as this paper will show, the current arrangements are financially and politically unsustainable, as well as opaque and unfair. Already, the system is starting to creak under demographic pressure. With social care costing each year around £13,000 for domiciliary care (support in your own home) or between £31,000 and £44,000 for residential care (support in a care home), this is only going to grow as an issue.

The problems in social care are already having a knock-on effect on other parts of the public services. Councils are having to devote an ever-increasing portion of their budgets to care, split roughly evenly between the elderly and others. And the success of the Government's 10-year plan for the NHS will, in large part, be determined by the social care system, given that the lack of care provision makes it harder to discharge people from care in hospital to other settings.

> **"A Conservative Party promise to allow people to keep £100,000 of assets whatever the costs of care – actually more generous than the system it replaced – was rapidly dubbed a 'dementia tax'."**

In a 2016 report, the National Audit Office found that delayed discharges cost the NHS roughly £1 billion. In the last 12 months for which records were available, delayed discharges totalled roughly 1.7 million days – of which two fifths were either solely or partially due to problems in the social care system.[1] Such delays, moreover, cascade back through the system, causing blockages all the way back to A&E.

1 NHS England, Delayed Transfers of Care Time Series, January 2019.

In response to the ever-increasing cost of social care, the Government has put in repeated doses of extra funding to keep the system moving. This is a sensible short-term reaction. But in the longer term this approach will need to be replaced with more systemic reform.

> **"The Dilnot Commission found that one in four people do not need any care at all – but one in five, at the other extreme, incur costs that are more than twice the average."**

So what do we want from our social care system? In many ways, the problem is similar to healthcare – particularly the uneven spread of risk. The Dilnot Commission on the Funding of Care and Support, which reported in 2011, found that one in four people do not need any care at all – but one in five, at the other extreme, incur costs that are more than twice the average. Which category you end up in depends not only on how long you live, but on whether you end up with a debilitating long-term condition such as dementia – which, as with so many illnesses, is largely beyond your control, and can cost as much as 40% more than non-dementia care.[2]

Voters understand this lottery element of social care all too well. And they are accordingly clear about their preference, with 80% of those who express a view saying social care should be "free for everyone who needs it". **This is my starting point as well – that a good level of care must be free to all at the point of use, regardless of circumstances**.

But while meeting that condition, any new social care policy must also fulfil four key principles:

1. It must provide more money for social care and ensure it is spent wisely.
There is no doubt that the existing system is struggling to cope at current levels of funding, and will not meet the inevitable increased demand in the years ahead. Currently, Government spends £11 billion on social care for the elderly across the UK, though roughly £2.5 billion of this is recouped through user charges. Another £7 billion or so goes into the system in private funding, giving a total of £18 billion. A joint report by the House of Commons Health and Local Government Select Committees last year estimated that in 2019-20, there will be a funding gap of £2.2 to £2.5 billion. The Government took steps in the 2018 Budget to mitigate this with £650 million of extra funding, but the pressures are still rising. Yet there is no point in increasing spending if it is not spent sensibly, so there needs to be an attempt to reduce costs across the system.

2. The system must be fair across generations and medical conditions, and to those who have saved.
Any reform must ensure that older people can obtain the care they need. But we must also avoid burdening working-age people with simultaneously having to pay both for their own future care and the care of previous generations. The system should also not discriminate between different conditions. Some long-term conditions, such as cancer, are treated medically by the NHS; treatment is therefore free at the point of use. Other conditions, such as dementia, are largely dealt with through the social care system, and can therefore end up costing individuals significant sums of money. A new social care system must end this "dementia lottery", meeting the needs of the patient whatever their condition. Older people should also not be penalised for having been responsible and saved through their lives. If they are being asked to contribute more, they should receive something for something.

2 Alzheimer's Society, Dementia – the True Cost: Fixing the Care Crisis, May 2018, p17.

3. The system must increase the supply of reasonably priced care options and retirement housing.
There is no point in fixing the funding of social care if there are not enough carers and care homes to cope with demand – or if a lack of competition in the sector means there is no pressure to improve quality and reduce cost. Sadly, at precisely the time when care provision should be rising, too many care homes are struggling because current funding rates are uncompetitive for providers. In addition, councils are currently incentivised to reject applications for new care homes and prioritise mainstream housing over retirement housing. We need to look at how we can improve this entire system, and build more housing and facilities suitable for older people.

> **"Councils are currently incentivised to reject applications for new care homes and prioritise mainstream housing over retirement housing provision."**

4. The system should aim to secure public and cross-party consensus.
This area has seen too many schemes being proposed that do not carry the majority of the public with them, and which are therefore opposed by one party or the other. There is therefore a need to set out something that is acceptable to the majority of the public and has political consensus (which are of course inextricably interlinked). That is the approach I have taken in this report.

A new Universal Care Entitlement and Care Supplement

There are two urgent tasks when it comes to the social care system: to stabilise the current financial situation and build a workable framework for the decades to come, around which a new political consensus can emerge.

The best model for social care, I argue in this paper, is the pension system – a guarantee of a reasonable universal safety net, but with extra individual provision encouraged on top. It is simple to grasp, fair in its operation and solves all of the major problems facing the social care system, as well as those other areas it impacts.

Under these proposals, the state would provide a Universal Care Entitlement, which could then be topped up by private support for those who want it via a Care Supplement. The Universal Care Entitlement would be at a flat rate level of support adjusted for need, whether or not the care was provided at home or in a residential setting, and wherever the care home was located.

This would involve moving from the existing system – in which the state provides care via local authorities – to a nationally funded model, where the state pays this set amount for each week or month that an elderly person needs support. This would not end councils' involvement in delivering social care, but would free them of a significant and increasing financial burden – as well as transform the incentives which currently prevent the construction of enough care homes and retirement housing.

We must also face up to the fact that the system requires additional funding. This report proposes a range of alternatives to fill the immediate funding gap, including taxing the winter fuel allowance; diverting savings from the Spending Review; and

as a last resort imposing a 1% National Insurance surcharge on those over 50 in exchange for a guarantee that their personal finances will not be exhausted by the costs of social care, and that they will be looked after whatever their condition. Together these add up to an extra £2.75 billion, which would represent a 25% per cent increase in the state funding coming into social care.

Extra funding is needed to stabilise the system and ensure that everyone has access to a reasonable standard of care. But in the longer term, we need to bring more private money into the system – not least to fund those who want more extensive or expensive care provision beyond the state-provided entitlement.

We therefore argue that people should be able to purchase a Care Supplement – something similar to an annuity or insurance policy – which ensures that money for more expensive care is available if needed. This money could come either from people saving small amounts across their working life; through the payment of a lump sum upon retirement, either from savings or existing pension pots; or via equity withdrawal from people's homes, which could potentially be realized through downsizing or a deferred payment when the property is sold. It is estimated that the financial gain an individual realizes when they sell their family-sized home and move into a retirement apartment is typically in the region of £60,000, and often more.

Taken together, these measures would put billions more into the social care system, and give further confidence to care providers to expand provision. They would also ensure that everyone received a good standard of care, that the "dementia lottery" came to an end, and that no one would be forced to sell their home or exhaust their savings in order to fund their care.

Fixing the structure of social care

It is not enough, however, simply to put more money into social care – wherever it comes from. We also need to reduce the cost and increase the quality of care, and thereby make the social care market work for the benefit of all who use it.

Back in the 1980s, care was a significant success story. Because it was supported via national rather than local funding, it meant councils were happy to see more retirement and care homes built. Provision of care beds nearly doubled between 1980 and 1990.

"Social care has actually become 20% less productive over the last 20 years, meaning we are putting in more for a worse service."

Once funding was localised, however, the total largely stagnated – because councils started to see the elderly, and facilities to support them, as a drain on their resources. Similarly, retirement housing's share of total housing is almost ten times smaller in the UK than in other, similar countries such as Australia and the United States.

The proposals here would encourage a similar success story – by increasing the provision of retirement homes, and holding down the costs of care. They would also boost productivity in the sector: scandalously, social care has actually become 20% less productive over the last 20 years, meaning that taxpayers are putting in more money for a worse service.[3]

3 ONS, Measuring adult social care productivity in the UK and England, June 2018.

Fixing the social care market would also have strong knock-on benefits for the NHS. At present, care homes often have to cross-subsidise those reliant on local authority funding, meaning they are often unwilling to take on such patients – especially those suffering from multiple chronic conditions who will need greater attention and incur higher staffing costs.

A properly funded Universal Care Entitlement would mean that hospitals could discharge into social care much faster, because there should always be care beds available – and the expansion of care home provision would help address the capacity problems in the sector.

“Fixing the social care market would also have strong knock-on benefits for the NHS.”

This shift away from councils feeling that older person housing was a cost would also mean that councils would be encouraged to support retirement housing provision, improving older people’s lives and reducing cost. To support this, I also propose that we create a new use class for older person housing and require councils to meet local need, in order to help drive this supply of housing up.

Conclusion

Taken together, this reform package addresses the most pressing issues regarding the social care system. It would give everyone a fair level of support through national funding. It would relieve councils of a significant burden and give private providers security to expand provision of care. It would preserve and expand the incentive to make provision for your own future if you wanted more than the generic standard of care. It would end the dementia lottery, keep people in their homes and be fair across and within generations.

Many studies of the social care system have already been carried out, resulting in many varying estimates of the size of the problem and the costs involved. It is of course vital that the numbers add up. But it is equally important – given the fate of so many previous proposals for reform – that we establish a broad framework for the social care system that is popular, fair and capable of generating political consensus.

I believe that this paper sets out such a framework – and can form the backbone of a sustainable system. I freely admit that these proposals would need to be taken forward and fine-tuned by Government, in consultation with the relevant sectors.

But taken as a whole, these proposals would put social care on a solid footing in this country. They would pave the way for better care for our older people – and eventually for all of us who need it.

Part 1
The Trouble with Social Care

How the current system works

Britain's current social care system is part private and part public. But it is unclear to most people what is available, what is funded by the state, and what needs to be paid for by the individual.

In general, care provided in people's own homes ("domiciliary care") is largely paid for by the state, with councils charging the full cost to those who have more than £23,250 in assets (that figure is higher in Wales and Scotland), or an income above a fairly low level (around £10,000 a year is often the benchmark).

However, the value of the main residential home is not taken into account, and individuals can protect their savings by transferring them to other family members (since this assessment is made at an individual not household level). In Scotland, as is discussed later on, some care is paid for at a flat fee level.

The second, and far more expensive, category is "residential care", in which the individual moves into a residential or nursing home. Individuals can be asked to pay for this according to similar criteria – except that this time they can be asked to sell their home to fund their care if their partner is not still living there.

There is also significant variation in the level of care provided, with more expensive care homes providing a much higher level of care. Councils may cover up to a certain amount, but the bulk of the cost tends to be picked up by those paying privately. At the top of the range, Berkeley Care Group homes cost between £1,300 and £1,800 a week per resident: all rooms come with a chauffeur-driven Mercedes for day trips out, fully equipped gyms and all-day bistro bars.[4]

> **"Britain's current social care system is part private and part public."**

For those who fall below the savings or income threshold, the state foots the bill. This is funded by local authorities through a combination of council tax, business rates, the adult social care precept and central government grant.

The broad outlines, in short, are the same everywhere – some people paying for none of their care; some people paying for all of their care; and some people covered by the council for some costs but not others. However, the detail of the system differs from local authority to local authority. In some care homes, for example, private and public patients are treated in the same way, however their care is funded. In others, the residents may get different treatment if they are paying more.

Due to the rise in the number of elderly people, councils are seeing an increasing proportion of their total spending go towards social care. In 2009-10, social care costs were 34% of local authority spending on public services (excluding education and public health). By 2017-8, this had risen to 41%.[5] While more than half of social care expenditure is on working-age people and children, the problems and solutions there are rather different – so this paper

4 Gill Plimmer, Financial Times, March 2017.

5 Institute for Fiscal Studies, Changes in councils' adult social care and overall service spending in England 2009–10 to 2017–18, June 2018.

focuses on the 20% of local authority funding that is spent on social care for the retired. Likewise, provision for the disabled is a vitally important topic but one that falls outside the scope of this report: I have therefore chosen to follow the Dilnot Commission's recommendation that current benefits be maintained alongside the wider reforms outlined in this paper.

One of the most obvious points about social care is that different individuals have very different needs and costs, often for reasons beyond their control. According to the Dilnot Report, the median care cost for the over-65s for the remainder of their lives was c. £25,000 in 2009/10. But the range was considerable, with 25% of over-65s requiring no care and 25% requiring more than £50,000 – twice the average. Around 10% faced costs of more than £100,000, and one in a hundred could expect costs in excess of an eyewatering £270,000. Updated for inflation, this means around £30,000 for the median patient, with 25% requiring more than £60,000.[6]

This makes social care similar to healthcare in many ways: a vital, hard-to-predict and somewhat random expense. And as with healthcare, the basic cost of provision will vary enormously according to condition, services needed and geographical location. Moreover, while in some cases it is possible to have a reasonable idea of whether a person is likely to need care, in most cases it is difficult to forecast.

Some people need full-time care, at which point residential care may be more cost-effective. However, people almost invariably prefer to stay at home – which is also cheaper both for them and for the state. The average cost of social care in a residential setting is £617, or £856 for a nursing home, amounting to £31,000 to £44,000 per year. That compares to £252 per week, or £13,104 in total, for 14 hours a week of home care (which works out at two one-hour visits a day).[7]

Total spend by type of care

Care Type	Average cost a week
Domiciliary	£252
Residential	£617
Nursing	£856

Total spending by type and source on social care for the elderly per year in the UK[8]

Total spending		**£18.4bn**
Of which	Private expenditure	£7.4bn
Gross public expenditure		**£11bn**
Of which	User charges	£2.6bn
Net public expenditure		**£8.4bn**
Of which	Domiciliary care	£2.6bn
	Residential care	£3.2bn
	Other services (such as assessment and nursing care)	£2.6bn

6 See Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support, July 2011, p112. Updated using CPIH-Consistent Inflation Rate Estimates for UK Household Groups (Democratic Weighting), ONS, November 2018.

7 Note that almost all figures in this area are slightly different – although they come from reputable sources, they vary due to methodological differences such as choice of data set. However, all tell broadly the same story. This particular estimate is from LaingBuisson, Care of Older People UK Market Report, 29th edition, 2018.

8 Based on PSSRU/LSE, Projections of Demand and Expenditure on Adult Social Care 2015 to 2040, June 2018, p8. Due to the lack of available data on the devolved nations compared to England, our figures are extrapolated from England-only figures through population weighting, to give illustrative UK-wide estimates. An estimate of £11bn for the value of public provision of elderly care is broadly consistent with IFS/Health Foundation estimates of £21.2bn spent on adult social care, of which just over half goes to the over 65s (see Securing the future: funding health and social care to the 2030s, May 2018, p11).

Where the money comes from

There are various different estimates of the cost of social care – which is why the sums below are indicative rather than definitive. But what is clear is that social care for the elderly comes at a fairly substantial cost.

The costs of residential care are split roughly evenly between the state and the residents themselves. On domiciliary care, the Government pays for a much greater share, with only a small top-up from private sources.

There is no commonly accepted estimate for private expenditure on social care, and the authors of the PSSRU/LSE analysis on which the table above is based suggest their estimate should be treated with caution. However, it is broadly useful in setting out the levels of spending from different areas and the aggregate levels of spend.

In total in the UK as a whole we spend around £18.4 billion on social care for the elderly, while we estimate that public spending on social care for the over-65s amounts to around £11 billion, or £8.4 billion once you take into account user charges. Private expenditure makes up a total of £7.4 billion – or £10 billion if you count user chargers as private spending.

The Institute for Fiscal Studies estimates that around 26% of domiciliary care recipients paid toward care in 2014-15 – but obviously not all paid the full price.[9] User contributions and self-funding are more prevalent in the residential/nursing sector.

Another estimate, from the healthcare consultancy LaingBuisson, suggests private expenditure on elderly residential care alone could be £6.9 billion,[10] meaning that around £0.5 billion is going towards private funding for domiciliary care. This broadly matches estimates from the UK Homecare Association, which suggest spending from self-funders on domiciliary care for all age groups (not just the old) could be worth less than three quarters of a billion pounds.[11]

It is important to note that this does not take account of user chargers. But given the IFS estimate that around a quarter of domiciliary care recipients are paying toward care, but not all pay all their costs, this probably means that between 10% and 20% of domiciliary funding will be private.

Broadly speaking, then, the level of private spending in the residential and nursing care home sector is likely to be around £8-9 billion, with the level of state spending around £6 billion.

The funding crisis

Although no part of the social care system is coping particularly well under the demographic pressures it faces, the part that is most in difficulty is the residential care system – which is also the most expensive.

While the Government's fiscal restraint from 2010 was necessary and right, local councils bore a large share of the burden. As their budgets came under pressure, many reduced the amount they were paying for social care, with spending falling by 10% adjusted for inflation.[12]

In such an environment, even private providers are nervous about investing in the sector due to uncertainty over future levels of payment for future care home residents.

9 IFS/Health Foundation, Securing the future: funding health and social care to the 2030s, May 2018, pXI.

10 LaingBuisson, Care homes for Older People market analysis and projections, May 2017.

11 UKHCA, An Overview of the Domiciliary Care Market in the United Kingdom, May 2016, p7.

12 Tom Calver and Daniel Wainwright, BBC News, December 2018.

In January 2017, LaingBuisson estimated that the shortfall in cash for local authority funded residents has created a roughly £1.3 billion a year funding gap in the care home industry.[13]

Analysis by the consultancy found that from a representative sample of both residential and nursing home fees, in 96% of cases privately paid fees were higher than council paid fees for like-for-like services.[14] This shows a clear subsidy from privately paid fees to the state sector. A further report in July 2018 noted that there is a subsidy from private self-payers to local authority residents:

> *"There remains strong evidence of a 'self-pay subsidy', with pure self-payers accounting for 52% of the market by value but only 45% by volume, making the market much more stable in areas of the country where there is a greater reliance on self-pay."*[15]

Last year, in an excellent joint report, the House of Commons Health and Local Government Select Committees estimated that despite some additional funding there would be a social care funding gap of £2.2 - £2.5 billion in 2019-20. This was before the 2018 Budget announced an additional £650 million on social care. Yet that would still leave a gap in total funding of £1.55 - £1.85 billion.[16]

A further confirmation that there is a significant funding gap came in a 2017 report by the Competition and Markets Authority, which concluded that the current model cannot be sustained without additional public funding. The report warned that while care homes can cover day-to-day costs, many do not have the capacity to sustain the business beyond the short term:

> *"Many care homes, particularly those that are most reliant on [local authority]-funded residents, are not currently in a sustainable position… This means that while they might be able to stay in business in the near term, they will not be able to maintain and modernise facilities, and eventually will find themselves having to close, or move away from the LA-funded segment of the market… fees currently being paid by LAs are not sufficient to sustain the current levels of care."*[17]

In the 2018 Budget Survey of the Association of Directors of Adult Social Services, 74% reported that care providers in their area were facing financial difficulties.[18]

This is not just a short-term problem, but a long-term one. Over the next 40 years, our population is projected to grow by around 10 million. But the fastest-growing segment will be older people, particularly those in the oldest age groups: the number of over-75s is set to double from today's 5.3 million.

This means that the demands on the care system – both for domiciliary and residential care – will increase hugely. Today around 250,000 over-65s receive long-term care at home which is at least partly public funded, and more than 150,000 are in residential care which is at least partly public funded.[19]

13 LaingBuisson, "Care Home Funding Shortfall Leaves Self-Funders Filling £1.3bn Gap," January 2017.

14 LaingBuisson, Care homes for Older People market analysis and projections, May 2017.

15 LaingBuisson, Care Homes for Older People, July 2018.

16 House of Commons Health and Social Care and Housing, Communities and Local Government Committees (Joint Report), Long-term funding of adult social care, June 2018, p10.

17 Competition and Markets Authority, Care Homes Market Study: Final Report, p13.

18 Association of Directors of Adult Social Services, Budget Survey 2018, June 2018, p18.

19 PSSRU/LSE, Projections of Demand and Expenditure on Adult Social Care 2015 to 2040, June 2018, p7.

The number of over-65s requiring 24-hour care is expected to rise by a third, to more than a million people. Among the over-85s, it is expected to double to just under half a million. This will mean that a tenth of all men and a fifth of all women over 85 will be in this high-dependency bracket.[20]

Even more alarmingly, the number of those who have dementia and at least two other major health conditions, such as obesity or diabetes, will double over the next 20 years – suggesting that an extra 500,000 people will need the most complex and expensive forms of care.

This would be a problem even if the care sector were ready to cope with this surge. But it is not.

In England, there are just over 16,000 care homes. Of these, 4,425 provide nursing care, and the rest offer residential care without nursing services. As mentioned above, many are already struggling financially.

> **"Over the next 20 years an extra 500,000 people will need the most complex forms of care."**

The care home market is dominated by private providers, although the market is not concentrated. As of January 2017, the largest four providers accounted for only 15% of all care home beds, while the top 25 accounted for 31%.[21] (As noted above, local authority funded residents account for more than half of care home places in both nursing and residential settings.)

Domiciliary care is an even more fragmented market. In 2016 there were 10,400 homecare providers. It is estimated that 70% of all homecare services in the UK are bought by local authorities from independent and voluntary homecare providers. The 10 largest providers have only a 16% market share.

Both domiciliary and residential services also struggle to recruit and retain staff. The vacancy rate for jobs across social care in 2017/18 was 8%, up from 6.7% the previous year. (In domiciliary care the figure was 9.9%, compared with 6.8% for care homes.) The turnover rate for care staff in England has also been increasing since 2012/13, and in 2017/18 reached 31% for all care staff. The rate was particularly high for care workers (38%) and registered nurses (32%).[22]

The impact of the current social care system on the NHS

One of the most significant problems with the social care system is the delays it involves. Patients frequently find it takes longer than they would like to get a place in a suitable care home; to arrange domiciliary care; or to get their own homes refitted to reflect their reduced mobility.

This applies not just to social care, but – as we are all aware – to the way it intersects with the NHS. In particular, even if social care providers have the capacity, they are unlikely to take on those patients who do not have funding in place; will be reluctant to take on those they have to cross-subsidise from other residents; and may well prefer to take on patients with simple needs rather than complex ones.

The net effect is a growing backlog of patients moving from the NHS into social care – both residential and domiciliary.

20 Comas-Herrera, Jagger and Kingston, Forecasting the care needs of the older population in England over the next 20 years: estimates from the Population Ageing and Care Simulation (PACSim) modelling study, The Lancet Public Health, August 2018.

21 House of Commons Library, Social care: care home market structure, issues, and cross-subsidisation, February 2017.

22 Skills for Care: Workforce Intelligence, The state of the adult social care sector and workforce in England, September 2018, p34 & p51.

NHS England publishes monthly data on how many days patients have been delayed in being transferred to a different care setting. The annual figure for 2017/18 was 1.98 million delayed days, of which 844,000 involved social care (697,000 were purely down to social care, with the other 147,000 blamed on both NHS and social care issues).[23]

Between 2010 and 2016, according to National Audit Office analysis, delayed transfers of care increased by 76% – with the rate of increase getting faster.[24] In a separate report, the NAO estimated that the gross annual cost to the NHS in England of older patients in hospital beds who are no longer in need of acute treatment is £820 million, meaning the whole-UK figure is probably roughly £1 billion.[25] However, they noted that this was likely to increase over time given the ageing population.

> **"Between 2010 and 2016, delayed transfers of care rose by 76%."**

There is, of course, a strong seasonal element to this problem. It is precisely at the times when the NHS needs to process patients most quickly, to make room for new arrivals, that the flaws in the system become most apparent – hence the perennial pressure in the winter months, which has often seen hospitals cancel all non-elective work in order to push more patients through the system, more quickly.

The impact of the current social care system on care homes and retirement housing

It is often pointed out that the social care system and the healthcare system are inextricably intertwined. However, it is less widely appreciated that social care also interacts – in a very damaging way – with local government in terms of housing, planning and finance.

As is explored further later on, overall, since 2000, productivity in the social care sector has fallen by nearly 20%.[26] There are many reasons for this, but a key factor is how local council funding interacts with the current system to create a lack of new and more productive care homes. This is a huge extra burden. It means that we have lost efficiencies worth some £3.4 billion since 2000 across the social care sector. If this is shared between the public and private sectors according to their total share of spending, it has cost the public sector £2.2 billion and the private sector £1.2 billion.

The reasons for this relate to how local councils are burdened with the costs of social care, making them reluctant to allow local investment. Any system needs to reform this so that we can start to reverse this alarming drop in productivity.

In addition, the UK has a very low level of specialist retirement housing being built. Current estimates are that up to 30,000 new units of specialist retirement housing should be built each year, but only around 7,000 units are being delivered.[27] More retirement housing would help improve choice and affordability in suitable accommodation for older people, but also help to mitigate social care reliance.

23 NHS England, Delayed Transfers of Care Data 2018-19.

24 NAO, Health and Social Care Integration, February 2017. 25 NAO, Discharging Older Patients from Hospital, May 2016.

26 ONS, Measuring adult social care productivity in the UK and England, June 2018.

27 Savills and Knight Frank (2016 and 2017).

A study by the Homes and Communities Agency found, for a typical person aged 60 and above, moving to specialist retirement housing generates health and social care savings of £3,500 a year.[28]

Increasing the availability of retirement housing is eminently achievable. To quote JLL on this:

> *"Only 0.6% of retirees live in Housing with Care, which is ten times less than in more mature retirement housing markets such as the USA and Australia, where over 5% of over 65s live in Housing with Care."*[29]

The UK's framework for delivering retirement housing has clearly gone wrong when we have so few homes compared to other similar countries. This means that we really need to focus on how we can change our retirement housing sector for the better.

28 HCA, Financial benefits of investment in specialist housing for vulnerable and older people, 2010, figure updated for 2010-17 using CPI inflation to reach £3,525 a year.

29 Retirement Living: Where is the Opportunity? Healthcare Research, JLL, November 2015.

PART 2
The Universal Care Entitlement

The social care system faces an unpalatable future.

Unless we address the issues outlined in the chapter above, we will continue with an inadequate system, funded either by increasingly cash-strapped councils or by forcing people to sell their homes.

If we go the former route, it is inevitable that as demand rises, councils will have to start choosing which of their non-statutory duties they drop or do less well to meet the needs of the social care budget. If the latter, we will be robbing people of assets they have worked their whole lives to own, and which formed the core of the inheritance they hoped to pass on.

In this section, I will argue that the best model for the social care system is the pension system. Everyone is given a reasonable state pension, but those who want something more attractive are encouraged and incentivised to provide for themselves. It is fair, it is politically attractive and widely supported – and it is a model we need to move across into social care.

What are the alternatives?

There have been many proposals for the future of the social care system. The most prominent, in 2011, was the Dilnot Report. The most notable element was the suggestion that everyone should have to pay the first £35,000 of their care costs, with the state covering the remaining costs once that cap was reached.

It also suggested that the £23,250 threshold at which people become liable for the full cost of their care should be raised to £100,000.[30]

A modified version of Dilnot was legislated for – but not enacted. In their 2017 manifesto, the Conservatives famously (or infamously) proposed that there should be a floor as well as a cap: that is, you would always be left with £100,000 no matter how expensive your social care became. This was, as mentioned above, actually more generous than the system it replaced – but the plan was seen as a "dementia tax" that would force people to sell their houses.

In November 2017, I was charged with producing a green paper to devise a new model for social care. The process is now in the hands of the renamed Department for Health and Social Care, with publication expected soon.

There are many good ideas in Dilnot and other proposals. But none of them pass all of the tests set out at the start of this paper – in terms of fairness, public support, ending dementia discrimination, letting people keep their homes and so on.

An obvious alternative would be to look overseas, and seek to learn from the best practices of our international peers. The House of Commons Library, at my request, prepared a comparative analysis of other healthcare systems (an edited version is published alongside this report on the CPS website).

30 Department of Health, Commission on Funding for Care and Support, July 2011.

But while my recommendations draw on the best systems from overseas, the research makes clear that there is no model that is obviously and palpably the best for us to learn from, let alone import wholesale.

As the Commission on the Future of Health and Social Care in England's "The social care and health systems of nine countries" concluded:

> *"No one country or model of provision emerges as an ideal. In a comparative analysis of the extent to which health systems deliver cost-effective care, the OECD found more variation within groups of countries with similar characteristics than between them, and that no one model could systematically be viewed as the most effective."*

All, in other words, have their strengths and weaknesses – and none offers a step-by-step blueprint for Britain to follow. The one thing that is generally handled better in other countries, however, is that they tend to have a clearer system that sets out the rights and obligations of those using the care system.

Another model, which has a significant following on the Labour benches, is to solve the problem of integrating health and social care by combining the two – either by establishing a National Care Service alongside the NHS, or by merging all care services into the NHS. As with the NHS, social care would become a service free at the point of use, paid for out of general taxation, with private provision only on the margin, if at all.

It is true that the current split between the NHS and social care is not a sensible one. And in terms of the tests set out at the start of this paper, proposals of this sort would certainly improve fairness, by redressing the imbalance between dementia and other conditions.

Yet both approaches have obvious practical disadvantages. A National Care Service would involve the creation of a large new bureaucracy which would inevitably absorb much of the extra funding in management costs. And complete integration with the NHS has alarming implications for the allocation of resources in the health service.

Many people are familiar with the issue of mental health services being the "Cinderella" of the NHS. This problem is now being addressed, for the first time, but it will take years to reach a satisfactory conclusion.

I would fear greatly that if the social care system were made part of the NHS we would create a new Cinderella service. It is inevitable that crises in emergency care, or more immediately visible diseases such as cancer, would dominate political priorities and therefore the thinking of the senior managers at the top of the NHS (who are vital in ensuring that decisions taken at the centre actually make a difference at the front end of service delivery).

At a local level I have observed for years that the NHS has a real problem in managing its various arms so that they work together. In particular, GPs can seem to be in an adversarial relationship with those who provide other NHS services, and especially those who manage them.

GPs work for themselves, manage their own practices, and often have an entrepreneurial small business attitude which sits uncomfortably within a large bureaucracy. It seems likely that providers of social care, who are often either private companies or individual entrepreneurs, would equally find the NHS blanket smothering rather than comforting.

Some will argue that the way to solve this problem is simply to nationalise the care homes, and have all services provided by the state. But since this would both be ruinously expensive, and antithetical to freedom of choice, I will rule that option out.

What is more likely to happen if social care becomes part of the NHS is a continuation of the mixed economy of private and public provision, but as part of the NHS. This would lead to the threat of money being diverted elsewhere in the NHS at times of stress (as mental health services have often found) as well as care managers having to deal with the complexities of NHS planning. It would also fail to solve the long-term funding issues, and mean that the attraction of setting up new care provision would be reduced.

The overall effect would be a system that was at least as strained as the one we have seen over the past 15 years. Worse, we would compound the fearsome demographic pressures facing the NHS by piling on the fearsome demographic pressures in the social care system as well. Senior NHS leaders shudder at the prospect of taking on the social care system precisely because they have enough on their plates already.

Copying the state pension

There is, however, an alternative model that could work. The state pension is workable, sustainable and politically strongly supported. Under this system, the state commits to provide a decent level of support that everyone receives. But people are free – indeed, encouraged and incentivised – to top this up with their own annuities and savings.

There is a genuinely mixed economy at work. No politician would dare abolish the state pension. But no reasonable politician would argue that it should be so expensive and extensive that private pensions did not need to exist.

In terms of social care, there will always be people who cannot afford to pay for their own care – or whose conditions make it far too expensive for them to bear the costs themselves. Everyone should have a route to a dignified old age, regardless of their economic circumstances or health condition.

Yet at the same time, we clearly cannot afford to give everyone in the country the kind of care provided by the most exclusive care homes. Not just because it would be unaffordable, but because it would be unfair – with the taxpayer subsidising non-essential luxuries for those who could well afford to pay for better treatment themselves.

My proposal is therefore that the Government adopts the state pension as the explicit model for the social care system.

The first step is to replace the current patchwork of provision with a new Universal Care Entitlement. This would guarantee a decent level of care in both homecare and residential settings, and basic accommodation costs if residential care is needed. This would give peace of mind to all older people whether or not they needed domiciliary or residential care. This level could then be topped up as people wanted.

The Universal Care Entitlement would operate in a similar fashion to the NHS tariff – delivered locally, but funded nationally. The care people received would have a cost attached, varying according to locality and type of care. They would know that they were entitled to a specified number of hours of domiciliary care per week, or a place in one of a range of care homes which included a set level of service.

There would still be a needs assessment, undertaken by local authorities. Those who needed either domiciliary care or residential care would be assigned a particular level of needs and given a basic level of funding to cover it. If you needed full time residential care, you might receive £2,000 a month to cover the core costs. Nursing care might be £2,500 a month under the Universal Care Entitlement, while people who required domiciliary care would receive £800 a month. (The Government should obviously consult widely on the exact level.)

In all cases people would be able to make top-up payments for additional services, but the assigned level of care would be a right – whatever their circumstances. The patient, their relatives or the council would apply to care homes or find a domiciliary provider; the provider would confirm eligibility with the council and deliver the required services. You would still be able to choose the home, or type of care, that was most suitable – but there would be a guarantee to the provider that money would follow.

Just as the state pension aims to keep all pensioners out of poverty while ensuring that those who provide for themselves are not penalised, so this Universal Care Entitlement would provide a good level of care if and when needed, without necessarily covering the "bells and whistles". It would be a level of care to look after those who cannot look after themselves, at a higher quality than they currently receive. The goal would not be to change the domiciliary system that much – since this is already covered largely by the state.

This system would be aimed at providing good care for all. The best current definition of "good care" comes in the recent joint report by two Commons Select Committees:

> *"Funding should be sufficient to achieve the aims of social care, which are to promote a person's wellbeing, independence and dignity and enable them to exercise choice and control over the way they live their life. This will require universal provision of high quality, personalised care delivered by a stable well-paid and well-trained workforce alongside well-supported carers to a wider group of people than currently receive care, all within a navigable and accessible system. It should also aim to address the current levels of unmet and under-met need."* [31]

This good level of care would be available to all.

But as with private pensions, the system should encourage people to take responsibility to improve their own condition in old age by using some of the resources they have built up over their life to provide them with what they want when they most need it – allowing people to enjoy a more attractive level of care while making sure that no one falls below an adequate care level.

If the Universal Care Entitlement was set at a reasonable level and available on a comprehensive basis, it would encourage wider availability of more ambitious residential care, and spur the whole sector to improve. In addition, it is likely that the profitability of providing these additional services would draw investment into the care home sector overall and keep prices low.

To avoid introducing too much complexity, the Universal Care Entitlement would apply only to those who were entering the social care system: existing patients would maintain their current arrangements. Because the time spent in a care home is not that long on average, with a median time of just 1.6 years, and less than 3.6 years for 75% of residents, the system would move fairly quickly to the new set-up.[32]

However, to achieve the provision of a Universal Care Entitlement within the wide-raging ambition of this definition, the current funding system will prove inadequate – even with the welcome extra money provided in recent years by central government. So we will need to support the system with a one-off step change in available funding.

31 House of Commons Health and Social Care and Housing, Communities and Local Government Committees (Joint Report), Long-term funding of adult social care, June 2018, p17.

32 PSSRU/BUPA, Length of Stay in Care Homes, January 2011, p4.

How much might a Universal Care Entitlement cost?

The key to making the Universal Care Entitlement work is ensuring that the money provided is sufficient to cover the current costs of local authority provision – in other words, to cover the transition from new system to old. This requires an injection of money – and in the medium and long term it needs to be supplemented by both increased private contribution and a greater supply of care provision in both residential and domiciliary settings.

We could try to find this money by freezing public spending on social care and asking people to pay for the remainder from their own pockets. But this would be extremely difficult politically – because it breaches the public's expectation that everyone will get a decent level of treatment. It also fails the "something for something" test by making people pay more for their care without getting anything back in return – which proved so toxic a concept in the 2017 General Election.

The goal of the Universal Care Entitlement is to create a system where basic needs are supported. Since domiciliary care is largely state-funded in England, changes here will be limited. In Scotland, however, they have already increased the support given to the over-65s, and we can use this to make a broad estimate of what the Universal Care Entitlement might cost.

The Scottish system provides free personal and nursing care, at rates of £171 a week for personal social care and an extra £78 if nursing care is also required.[33] This takes care of personal hygiene, diet, mobility, treatments and personal assistance – similar to our Universal Care Entitlement, although it does not cover core accommodation costs. The total cost is £123 million a year. If we were to add the cost of basic accommodation on top, it would double to £246 million a year (these are obviously approximate figures).

Adjusting for the size of England's population the change would mean roughly £2.5 billion extra cost per year, in terms of supporting basic care needs for those who currently have to pay in directly.

> **"The goal of the Universal Care Entitlement is to create a system where basic needs are supported."**

How could we make up this funding gap, and put the system on a sustainable footing? I urge the Government to consider three options, in decreasing order of preference:

- Taxing the winter fuel allowance
- Making wider savings as part of the Spending Review
- If necessary, putting an extra 1% on National Insurance for those aged over 50

Taxing the winter fuel allowance

The Conservative manifesto in 2017 made a specific pledge to means-test winter fuel payments, with the money saved "transferred directly to health and social care". This policy was dropped after negotiations for a confidence and supply agreement with the Democratic Unionist Party.

A simpler, and less controversial, system would see the winter fuel allowance added to each person's taxable income – while being withheld altogether from higher rate taxpayers (who make up a very small number of very affluent pensioners). This means you do not need a separate and more complex clawback mechanism. This would raise £350 million a year towards social care.[34]

33 Scottish Government data available at https://www.gov.scot/publications/free-personal-nursing-care-scotland-2016-17.

34 Removing the WFA from higher rate taxpayers would raise £100 million, and approximately £250 million would be raised from taxing the WFA for basic rate taxpayers by 2019-20. See Hansard, Steve Webb Written Answer (DWP), c148w, January 2013.

Making wider savings as part of the Spending Review

The second option is to redeploy savings from other parts of Government into social care. The tax burden is forecast by the Office for Budget Responsibility to be £736.1 billion in 2018/19. This represents 34.6% of GDP, which is the highest level since 1969/70.[35]

The Centre for Policy Studies will, ahead of the Spending Review, be publishing work on areas within this spending envelope where the Government can make substantial savings. It has argued elsewhere that many of the savings it identifies should be used to ease the tax burden on the low paid, especially those coming out of welfare and into work. In another CPS report, Matt Warman MP highlighted the savings that could be made in local government by promoting unitary authorities, or devolving more spending decisions. Some of the money from such savings – or others identified by the Government – could and should be injected into the social care system, given the consensus (outlined above) that extra funding is needed.

A possible 1% National Insurance Contribution for those aged over 50

A final possibility, if the Government needed it, would be asking all those over 50 to pay an extra 1% National Insurance contribution. This is very much a last resort, but it should remain on the table.

Above all, this would need to be done in a way that ensures that people feel it is fair. By 50, most people will be considering their care needs – a survey of 1,000 older people in 2014 found that this is the average age that people started to worry about getting older.[36] It should also be an age when most people have paid off a large part of their mortgage, and are starting to consider how to support themselves in old age.

Using the latest available data on the income and tax paid from HMRC,[37] there are about 7.9 million taxpayers aged between 50 and 64. We estimate that they have a mean income of about £39,210 per year. The National Insurance threshold was set at £8,424 in 2018/19, so the mean taxable income for these taxpayers was about £30,786. A 1% levy, which would mean an extra £308 a year for the average taxpayer between 50 and 64, would raise £2.4 billion a year – enough money to cover the funding gap. And while hypothecated taxation is rarely a good idea, it would be politically essential to make clear to this group that the money involved was going solely and directly to the care of the elderly, including their future selves.

> **“ For social care to be truly sustainable, we need to encourage private provision as well. ”**

Taxing the winter fuel payment and taking it away from those who are higher rate taxpayers, allied to either a National Insurance top-up or wider Government savings, would inject £2.75 billion into the system targeted only at residential and nursing care. This would be on top of the £6 billion or so that is already provided by Government.

This would cover the cost of the Universal Care Entitlement based on extrapolating the cost of providing care in Scotland to all, and put the system on a more sustainable footing in terms of making sure that everyone could have a good level of care.

However, to be truly sustainable, we need to encourage private provision as well, particularly for the more expensive non-care elements such as more expensive housing, which can help the sector overall. It is to this issue that I now turn.

35 For data on the level of national account taxes and size of the economy see OBR, Public finances databank.

36 CloudBuy, Survey into the Concerns of Ageing, April 2014, p7.

37 HMRC, Distribution of median and mean income and tax by age range and gender, March 2018.

PART 3
The Care Supplement

Under the Universal Care Entitlement, the state would commit to providing a basic and good level of care – a significant reassurance for those who could not afford to fund their own social care, and also a way to ensure people are not discouraged from looking after themselves, or forced to run down their assets in retirement in order to qualify for an arbitrary threshold for free treatment.

But even if the Government does inject more money into the social care system, we will still not be able to give everyone the most expensive quality of care and quality of life – and never will.

So as with the pension system, we should also seek – at every stage – to encourage people to provide for their own futures, by putting money aside to top up their care and guarantee themselves peace of mind in their old age, not least when it comes to having to sell their home or face the costs of dementia.

At the moment, as outlined above, there is a significant "cross-subsidy" within the care home system. Those paying for their own care, in whole or in part, are seeing their contributions used to subsidise the care of other, poorer patients.

A key aspect of the Universal Care Entitlement is that, like the state pension, everyone will be able to claim it. This means that some core treatment costs which are currently being covered privately will be covered under it – everyone will be guaranteed that set level of treatment.

For the social care system to be secure over the long term, we need to increase the level of private funding flowing into the care system – but we also need to ensure that people are getting "something for something". We cannot simply ask them to pay more from their own assets or savings to cover their care costs without offering them something in return.

What I propose is that the Universal Care Entitlement should be accompanied by an optional Care Supplement – a new form of insurance designed speficially to fund more extensive care costs in old age, such as larger rooms, better food, more trips, additional entertainment and so on.

The inspiration for this would be the private pension system, which sits alongside and supplements the state pension – and is, increasingly, the norm.

> **"We should seek – at every stage – to encourage people to provide for their own futures."**

There would be one significant difference from the pensions system, however. Instead of simply receiving back whatever amount was in your pot, you would pay a set level upfront for one of a tier of products – for example, a £10,000, or £20,000, or £30,000 package, which promised a specified level of care in addition to that provided under the Universal Care Entitlement.

These products would be standardised rather than personalised – in other words, insurers would not be able to charge you more because of what their testing had found in your genome, or because you had a family history of dementia. The reason for this is that, as mentioned above, social care needs are unpredictable. Some people will not need any care at all – others, especially those with conditions such as dementia, will need expensive and extended support.

What these products offer, crucially, is peace of mind. By pooling risks, the insurers offering these products will be able to guarantee good treatment – while cross-subsidising the most expensive patients with those whose needs end up being less intensive (or who do not end up needing care at all). And with a functioning insurance market in place everyone will have a guarantee that that is the limit of their costs – with no need to run down assets or sell your family home.

So how do we go about setting up such a system?

I propose that as people approach retirement, the Government should nudge – and, if necessary, shove – them towards putting money aside for this. They should be reminded about the Care Supplement when they hit 50, or 60, or when they take up their pension. Investment or savings products could and should also be developed which offer people the chance to compound the income they are paying in, in order to maximise the sum available later in life. (Indeed, this could link to the Lifetime ISA product.)

The key to this offer is flexibility. People could save in whatever way was most suited to their abilities, and their lifestyle. If they did not want, or were unable, to put smaller sums aside on a regular basis, they could instead pay a lump sum on retirement – either taken from their wider pension pot, via equity release (deferred until after death if preferred), downsizing or from other assets or savings. There is also the possibility of the Government introducing an "opt-out" system, akin to pensions auto-enrolment, so that people save for their social care needs by default.

A big reason to adopt the Care Supplement model is that it ensures that payment is voluntary – people will have a choice about whether to pay, rather than seeing their tax bills inexorably rise. However, to ensure take-up is sufficiently high, information and education are going to be vital. For example, research by the Association of British Insurers (ABI) found that only 14% of people realised that a year in a nursing home could cost more than £30,000.[38]

> **"What these products offer, crucially, is peace of mind."**

Yet there is an applicable model in how private pension saving is encouraged in Australia. Since 2004, the Australian pension industry has operated a "Retirement Standard". This sets out a series of potential retirement outcomes ("modest retirement", "comfortable retirement", etc) with illustrative examples of the standard of living retirees can expect at each income level (such as whether they could afford annual foreign holidays, eating out once a week, etc).

Evidence suggests that this sort of guidance can have a significant psychological impact, encouraging people to think seriously about their retirement goals. A similar system could work well

38 Written evidence from the Association of British Insurers, House of Lords Economic Affairs Social Care funding inquiry, November 2018: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/economic-affairs-committee/social-care-funding-in-england/written/91955.pdf.

39 Pensions and Lifetime Savings Association, Hitting the Target: Delivering Better Retirement Outcomes, October 2017, pp21-22.

for the Care Supplement, giving people a better idea of how much they will need to be paying in to ensure they can enjoy the quality of care they want for themselves.[39]

There is of course a question about the "long tail", the few patients with cripplingly expensive care needs. Andrew Dilnot's commission believed that for a functioning insurance market to develop, such patients would need to be underwritten by the state. But our model solves this problem by guaranteeing a decent level of care to all. The ABI have previously noted that "internationally private insurance appears to work best when complementing the state and the family in funding care", ideally with "predictable universal partial coverage", and where "the public system entitlement is clear".[40]

A 2012 University of Kent discussion paper which compared the markets for long-term care insurance across major developed countries concluded that *"The experience of other countries suggests that private insurance for long-term care could potentially have a bigger role to play in the financing of long-term care."*[41]

Funding the Care Supplement

In the long term, we would hope and expect that saving for the Care Supplement would become the norm – people would build it into their assumptions about old age. But if that happens, then how much money would it raise?

The total amount of housing equity owned by people over the age of 65 in Great Britain is £1.56 trillion. The amount of housing wealth for each year in the over-65 cohort works out at just under £100 billion.[42] On top of this, for every £1 of residential wealth there is a further £0.63 in non-residential wealth for households – excluding pensions.[43]

This means that as it turns 65, each annual cohort possesses approximately £163 billion in non-pension assets.

To work out how much extra the Care Supplement might contribute to social care spending, we will need two variables:

- The number of people who might take it out.
- The extent to which they would trade the one-off cost of the Care Supplement in order to protect the remainder of their wealth.

"The total amount of housing equity owned by people over the age of 65 in Great Britain is £1.56 trillion."

On the first point, we could, at the top end of the scale, assume that the Care Supplement will have the same hit rate as auto-enrolment – strong take-up of which saw the number of employees with a workplace pension soar from 55% to 84% between 2012 and 2017.[44] This would assume that we considered a nudge, or even auto-enrolment at the higher end of this range.

Since home ownership among older people peaks at around 80%, and those who do not own a home may only have limited savings in most cases, the latter figure is a rough upper boundary for the number who could potentially have the resources to pay for their own care.[45]

40 ABI Pensions and Insurance Working Group, Developing Products for Social Care, 2014, p8.

41 Comas-Herrera, Fernandez-Plotka & Wittenberg, Barriers to and opportunities for private long-term care insurance in England: What can we learn from other countries?, PSSRU (University of Kent), August 2012.

42 Savills, Over 50s hold 75% of housing wealth, April 2018.

43 Calculated based on Distribution of aggregate household total wealth by age and wealth component, Great Britain, March 2018, Table B (using aggregates of the 65-74, 75-84, and 85 and over age groups).

44 DWP, Automatic Enrolment Evaluation Report, December 2018.

45 ONS, UK Perspectives 2016: Housing and home ownership in the UK, May 2016.

It is of course extremely optimistic to imagine that take-up of the Care Supplement will be as extensive as pensions auto-enrolment. So let us be more pessimistic and say that a better proxy is the number of people taking out life insurance, since it indicates a similar propensity to guard against an uncertain future.

Around 48% of people aged 45-54 – the age when family, mortgage and other commitments peak – have life insurance.[46] This seems a reasonable proxy for the lower bound on social care, in terms of how many would take up the Care Supplement at the age it was offered.

At a rough estimate, then, between 50% and 80% would likely be in the market for the Care Supplement, assuming it was an attractive enough product.

The question then becomes how much of their wealth people are willing to commit to buying such insurance.

People obviously have an incentive to pay into a private pension, because they are guaranteed to get the benefits (unless they die well before their time, and even then, a loved one will benefit instead). It is also easy to persuade them to take out insurance for other risks – such as fire, or theft, or skiing accidents – because while the likelihood of experiencing loss is low, the costs are disproportionately high.

In terms of social care, the odds are more finely balanced. Many people will need it – but equally, many will want to save themselves from the risk of having to sell their house or otherwise exhaust their assets.

Based on a study of existing insurance models, I have used a rule of thumb which says that people would be willing to put aside 5-10% of their housing equity in order to save the remaining 90% for themselves and their families.

Given between 50% and 80% taking out a Care Supplement, who would be willing to put aside 5-10% of their assets in order to protect the rest, that annual wealth total of £163 billion gives you a figure of around £4 - £13 billion entering the system each year. In reality, I think that this figure is likely to be closer to the lower end than the higher end, but I include the full range as there is a possibility that we reach the top. We do not think that the funding would be lower than the bottom of this range.

“There is more than enough money available from existing housing wealth to fund the kind of insurance market set out here.”

Another way to estimate the amounts available would be to start with the number of people, rather than the amount of assets. There are currently at least 700,000 people crossing the pension threshold every year, a figure which will rise in the coming decades to more than 900,000 when those in their late forties hit retirement.[47]

Let us say, as above, that between 50% and 80% of these people have the means and motivation to subscribe to the Care Supplement. At a £10,000 level, that is between £3.5 billion and £5.6 billion in extra funding going into the system, with more to come as the numbers entering retirement grow. If the entry level for the Care Supplement was £20,000, the numbers would be higher still. (Obviously, the higher the basic level of the supplement, the fewer people will be inclined to take it up.)

46 YouGov (Andrew Farmer), One in five no longer have life insurance policies, March 2014 and ONS, Overview of the UK population, July 2017.

47 ONS population pyramid at https://www.ons.gov.uk/visualisations/nesscontent/dvc219/pyramids/index.html.

This exercise is only approximate. But it illustrates that even without anyone increasing the amount they are putting inside in savings, there is more than enough money available from existing housing wealth to fund the kind of insurance market set out here – and to deliver a better quality of care.

As outlined above, the entire private contribution to the social care system at the moment amounts to £10 billion including user charges. Any sum that the Care Supplement would provide would therefore be a major increase – even using the lower range estimate at £3.5 billion, this would be around a 50% increase each year.

The really important thing, of course, is not that more money would be going into the system. It is that you would be able to offer peace of mind both for the individual paying the premium and their family. And it would be clear that you would get something for something – you would pay more to obtain more.

None of this, of course, precludes people opting out of the system – or deciding that they would like a more attractive care home despite not purchasing a Care Supplement. In such cases, they would be able to sell their property or use their wealth to pay for care as currently.

However, because there would be no pooling of risk for these people, the cost of any extra support would be directly paid by the care recipient. If you owned a house and did not take out a Care Supplement, and then became ill, you would receive the Universal Care Entitlement and so get support for your core care needs. But if you wanted care in a more desirable setting (e.g. a more attractive care home, more trips out, more activities on site) then you would need to pay for this entirely yourself using savings or housing equity.

Since contributing would be encouraged rather than compulsory, the Care Supplement would not be a tax, or any kind of state confiscation of wealth. It would instead encourage more people to save more for their old age, without introducing any new element of compulsion. This would be clearer and fairer than the current system of state and private provision.

Introducing the Care Supplement for those already in the system

The Care Supplement system, once introduced, would be designed to sustain the social care system over the long term. But it would also provide an immediate short-term boost as well – as well as providing immediate peace of mind to those already drawing down their pensions.

> **“The important thing is not the money, but the peace of mind both for the individual paying the premium and their family.”**

As I have said, the total amount of homeowner equity among over-65s is £1.56 trillion. Once we add in non-pension wealth, at the same rate of 0.63p per £1, this gives us £2.54 trillion. If even a fraction of this entered the system, it would revolutionise social care.

Obviously, the risk-pooling system would have to work differently for those already aged over 65. If you are still alive and healthy aged 80, your chance of needing care is higher than if you are alive and healthy aged 65.

But this can be left to the market – the important thing is to be able to offer the guarantee that for a set price, those of pension age will not have to sell their homes, and will be safe from the dementia lottery, and be able to rely on the Care Supplement to top up the Universal Care Entitlement provided to everyone.

We could even offer a version of the Care Supplement to those who are now entering care, since we want to encourage people to pool risk. This would inevitably purchase a lower level of support, given that it would not be cross-subsidised by those who never needed care but purchased a Care Supplement – but it would still buy that same peace of mind and allow people to pool and share risk.

How the pension model helps the NHS

As discussed in Part 1, there is an urgent and widely recognised need to ensure that people can move seamlessly from the NHS into social care. There is a real problem at the moment in getting people through the system, which is causing substantial delays, incurring substantial costs and threatening the functioning of the entire healthcare system during the winter months.

The Universal Care Entitlement will help address this issue of delays, since it will incentivise care homes to take more patients. But there is the potential to do more.

Under the NHS tariff system, the government pays a set amount per patient, depending on their condition and treatment.

For each extra day a patient stays in hospital, the average amount paid under the current tariff is £261.[48] This compares to an average cost of care for older people in a nursing home of £87 per day or local authority residential care at £78 per day.

This saving of £170 a day may not sound much, but given that there are over 52 million hospital "bed days", the potential savings are enormous.

If, for example, you could accelerate the speed at which people are discharged into social care so as to reduce the number of bed days by 10%, it would produce savings of £1 billion a year.

> **"For each extra day a patient stays in hospital, the average amount paid under the current tariff is £261."**

We propose that, to further the integration of health and social care, NHS hospitals are able to buy places in the social care system either at that lower rate, or the equivalent level to the Universal Care Entitlement threshold when it is set by government. This could either be used to save the NHS money – or to provide more space for new patients to use those desperately needed beds, speeding the flow of patients through the system.

This would help to ensure that the current major increase in funding to the NHS over the period of the next Spending Review is supported by wider reform to ensure that social care can play a positive part in supporting the NHS in the coming years, rather than acting as a drain and lowering productivity in healthcare more widely.

48 NHS Improvement, National tariff payment system 2017/18 and 2018/19, Annex A.

PART 4 - Reducing the Cost of Care and Improving its Quality

There is an obvious and pressing need to increase the levels of money flowing into the social care system.

But this will do little to put social care on a truly sustainable footing unless we also fix the supply side – in terms of both the care market itself and retirement housing.

The current system is arranged in a way that discourages investment in new care home facilities by penalising councils which support it and discouraging councils from giving planning consent for new retirement housing developments. Both these factors end up raising the cost of care, as well as lowering the quality of life for older people.

So on top of the changes already proposed, there are two areas that we need to tackle in order to reduce the cost of care and offer a better service to the elderly. First, we need to focus on increased and better care home and domiciliary support. And second, we need to focus on a major increase in retirement housing.

Once we have fixed the issues around councils being discouraged from providing this, we then need to look at how we can make councils live up to their responsibilities in this area to help reduce the cost of care and improve its quality.

The provision problem

As we discussed in Part 1, the UK suffers from a massive under-supply of retirement housing, with far fewer retirement homes – as a share of total housing – than countries like Australia and the United States.

It is hardly news that Britain is not building enough houses, of any type. But there is a particular problem with the lack of retirement housing. Councils are not responding to need and supporting the growth of retirement housing in their areas – in fact, despite the pressing need for more retirement housing they are actively incentivised to block such applications.

Essentially, many local authorities are wary of importing too many elderly people because they can see their care costs mounting up in the years to come, despite the evidence showing that older people moving into retirement living typically move only a short distance from where they already live and so remain within the same council authority. Councils in general are spending ever-increasing amounts on social care – but the problem is particularly acute for those which find themselves losing workers and fearful of gaining OAPs in large numbers, for example the coastal towns. The result is a one-two punch: a fast-eroding tax base coupled with fast-rising costs.

The worse these financial pressures get, and the more severe the problems with social care, the more nervous councils become of approving planning applications for new care homes or retirement housing.

At a Centre for Policy Studies debate on housing for the elderly last year, many councillors said that they had directly been told by other councillors that they could not support housing for older people in their area, because it would destabilise the local care system and effectively create a significant additional cost burden for the local council.

This mismatch between supply and demand is neither natural nor inevitable. It is the direct result of a system which forces councils to choose between saving themselves money – by building less accommodation for the elderly – and saving money for the country as a whole.

That is because the same incentives that push councils to avoid approving new retirement housing result in a higher bill for the state as a whole.

Returning to what works

Our proposals replicate a past system that had worked very well. In the early 1980s, the decision was made to guarantee national funding for those social care patients who could not afford to pay. This had two vital positive impacts:

- Private residential care could expand, with operators knowing they would be supported financially as long as the costs were not excessive.
- Local councils were happy to oversee this expansion of supply, as it had no impact on their budgets and funding.

The result was a boom in the number of care homes, and the volume of care home provision.

UK social care bed provision[49]

Year	Care bed provision	% growth per decade
1970	193,000	NA
1980	241,000	25%
1990	444,000	84%
2000	504,000	13%
2018 (England only)[50]	404,163	NA

As the table above shows, between 1980 and 1990 social care bed provision grew by a huge 84% across the UK, much faster than before or since.

Even accounting for the fact that the figure for 2018 is England only, which makes a perfect comparison impossible, it is clear that care bed provision has not increased much in recent years. Separate data showed that between 2012 and 2017, the number of care home beds in England increased by just 4.3% – while the number of people aged over 85 rose by 16.2%.[51]

A key factor is that in 1993, the NHS and Community Care Act reforms saw responsibility for care funding transferred to local authority budgets, with care management to help assess individual needs. Councils, responding to incentives, started to be less keen on encouraging older people into their area, because it meant more bills to pay. Sure enough, care home provision slowed dramatically.

The Competition and Markets Authority argues that *"the current funding situation combined with uncertainty about future funding means that investors are reluctant to come forward to build the additional*

49 Peace, The Development of Residential and Nursing Home Care in the UK, 2003.

50 Oxford Brookes University: Institute of Public Care, Market Shaping in Adult Social Care, July 2017.

51 Oxford Brookes University: Institute of Public Care, Market Shaping in Adult Social Care, July 2017, p5.

capacity needed… investors are reluctant to invest in additional capacity focused on LA-funded residents." [52]

This has impacted on not just the stock of care home places, but their quality. A review by Christie and Co. found care homes built after 2000 tended to have better facilities, with *"a substantial difference in the quality of assets and their suitability for residential care purposes between homes developed before and then after 2000 – the majority of facilities developed post 2000 are purpose-built facilities with an architecture to facilitate high-quality and efficient care, appropriate levels of social space and amenities such as a hairdressing salon and café"*.[53]

The problem is that, as Christie and Co. also found, only 17.2% of cares homes fell into this category of post-2000 homes.

"Getting back to the same levels of efficiency as in 2000 would be equivalent to a £3.4 billion cash injection."

Not only are older buildings more expensive to maintain, but they are often not the right size. The CMA found that *"care homes have 40 beds on average. The average size of a care home has been gradually increasing with the optimum size considered to be around 60 to 70 beds."* [54]

Larger care homes are able to offer better economies of scale – not just in terms of staffing costs, but in terms of more space for kitchens, social spaces, hairdressers and so on.

This is particularly important since the standard of living that people expect in care homes has, rightly, been rising.

The fact that care homes are, on average, older and smaller than they need to be has a crucial knock-on effect. Productivity in the care home sector has been steadily falling in recent years – resulting in a lose-lose situation where the Government has to pay more, and the quality of care still deteriorates.

This helps explains why, since 2000, productivity in the social care sector has fallen by nearly 20%.[55] If we could reverse this – just getting back to the same levels of efficiency as in 2000 – it would be the equivalent of a £3.4 billion cash injection. Even just making good half of the productivity damage would inject another £1.7 billion, equal to a 15% increase in Government support for social care.

For councils, the reformed system outlined in this paper would break the link between size of the elderly population and pressure on social care budgets. This in turn would make them councils feel that they could expand the supply of local care provision and retirement housing. This would free them from the present tragic dilemma under which the councils that do most to live up to their responsibilities to the elderly face the gravest financial pressures. It would encourage a major increase in care provision and help increase productivity as well, a win-win situation.

52 HCLG Select Committee, Written evidence submitted by the CMA, March 2018.
53 Christie and Co., Presentation to the National Care Association, November 2017, p13.
54 CMA, Care Homes Market Study, November 2017, p33.
55 ONS, Measuring adult social care productivity in the UK and England, June 2018.

Delivering more and better care provision due to guaranteed and higher payments

Moving to a system in which local councils do not see elderly people as a drain on their budgets will certainly help increase provision. But if we want to repeat the major increase in care home capacity seen in the 1980s, we need to do everything we can to encourage private provision too.

> **"Changing the incentives will make councils look more kindly on proposals for purpose-built housing for the elderly."**

Research by the Competition and Markets Authority suggests that the limited number of providers who are currently building new care homes are actively choosing locations with higher proportions of self-funded residents and avoiding other areas. Investment in new care homes is also going almost entirely into those aimed at self-funded residents, with negligible sums directed at the local authority funded ones.[56] At the same time, capital expenditure on existing care homes of this kind has largely been limited to basic refurbishments or improvements necessary to meet minimum care standards.[57]

Not only do these proposals ensure councils have no reason to prevent care homes being built, it also gives care providers positive reasons to expand. By giving care home providers a guarantee of payment for each patient, and eliminating the gap in funding for those accessing the core social services provided by the Government, we will give them confidence to invest. Creating a pool of funding for private top-ups will also ensure that more money flows into the sector.

Under the new system, councils will still have an important role, coordinating between patients and care homes, and making available online CQC reports on local care homes so that those having to plan for this eventuality can be as well informed as parents choosing a school for their children.

However, because the system will not be paid for by councils, their role will be to oversee and supervise. This will help to encourage an honest assessment about needs in the local area, as it will no longer be in councils' interest to discourage the construction of care facilities. Indeed, councils will feel that they should encourage good care provision in their area because it is something that local voters are keen to see (especially since older voters tend to be more likely to turn out in local elections).

Increasing the supply of retirement home provision

Not only is there a supply side issue, there is a demand side issue. At present, people fear the potentially unlimited cost of social care, should they lose the dementia lottery.

The result is that elderly people are tending to stay in homes that are often larger than they need, and potentially unsuited to their needs. As with so-called "bed-blockers" in the NHS, this flows back through the system, meaning that the next generation down cannot move into larger family homes because their current residents are not selling up.

No one should be forced to sell their home. But as pointed out above, Britain's stock of housing specifically designed for the elderly is pitifully small. Research undertaken in 2018 by McCarthy & Stone indicated that 1 in 5 people aged 60 or over would be interested in downsizing to a retirement property were the right place available.[58]

56 "Care Homes Market Study: Appendices and Glossary," D3.
57 "Care Homes Market Study: Appendices and Glossary," D3.
58 Retirement Confidence Index, McCarthy & Stone, August 2018.

So how do we change this? Obviously, changing the incentives will make councils look more kindly on proposals for purpose-built housing for the elderly. They will no longer be forced to choose between what is best for them as a council and what is best for their residents – and for the country as a whole.

Some of the blockages to this happening are not regulatory or financial, but emotional and cultural. For the individual, or couple, their house is not just a store of value but a store of memories. For many people it is a significant part of their identity. Equally importantly, it may be an even greater part of their children's identities: not an asset, but a home.

The lack of specialist housing for the elderly itself contributes to the growing demand for more expensive care home places, and the pressures on the NHS. Even more importantly, it reduces the quality of life of older people.

It is an almost universal phenomenon that people want to stay in their own homes for as long as possible. It is hard to quantify the impact that being forced out of your home has on your quality of life. But it is certainly possible to quantify the healthcare impact. As we noted in Part 1, each year that people spend in retirement housing saves the Government £3,500. Another study has found that on average, costs for those with entry-level social care needs were 17.8% lower in specialist accommodation vs general needs, saving £1,222 per person per year. For those with more intensive social care needs. the savings were greater, with a 26% cost difference between specialist and general accommodation, saving £4,566 per person per year.[59]

Creating more specialist retirement housing, which people could downsize to at the appropriate moment in life, would save the individual, the NHS and the local authority money. We therefore need to do all we can to encourage downsizing into retirement homes as the last piece of the social care puzzle.

The introduction of a Universal Care Entitlement should remove the disincentive for councils allowing more to be built. However, it will take time for councils to begin to focus on developing this area and the Government needs to push them to ensure that more is done in the short to medium term.

"It is an almost universal phenomenon that people want to stay in their own homes for as long as possible."

I propose that the Government takes forward two supporting measures as recommended by the House of Commons Housing, Communities and Local Government Select Committee:

1. Requiring every council to have a target of housing for older people in their local area, with a strategy on how this will be achieved.
2. Creating a "use class" to help achieve meeting this target.[60]

I would then add that the Government should start consulting now on what action should happen if a council fails to meet its target, so that areas which are not meeting the needs of older people would see measures being taken to bring them up to scratch. In the long run, this target is likely to prove redundant, but given the current failure to support older person housing, there is a need for a short-run push by the centre on this.

59 Extra Care Charitable Trust/Aston Research Centre for Healthy Ageing, Better Lives, Health, Future, June 2015.
60 Housing for older people, House of Commons Communities and Local Government Committee, 2018.

As the Select Committee discussed, there is clear evidence that land is difficult to obtain for older person housing. Even where the council was ambivalent or supportive of retirement housing, there were issues that would make it more difficult, not least the fact that older person housing has a higher level of communal areas and other costs which make it more expensive to build than other types of flat (all other things being equal), and which often mean long and difficult wrangles in planning, which can sink projects.

Sadly, in some cases this wrangling is likely to be just a way to block such housing, but we cannot assume this to be the case across the board. Those who build such retirement developments and the Select Committee argue strongly for a complete exemption for Section 106 and Community Infrastructure Levy costs, which are usually charged in return for planning permission.

At the very least, creating a new use class would allow for a more realistic and simpler system that charged a lower rate for retirement housing than for other housing (just as already happens with student housing in many areas, where it is understood this has a different cost base from typical homes, and this makes it much quicker and easier to get sign-off).

A more streamlined planning regime for retirement housing would also encourage existing mainstream developers to enter the retirement market as part of their portfolio on a development, thereby supporting the diversity of mix recommended in the Letwin Review.

For understandable reasons, many of the public policy incentives to date have favoured conventional mainstream housing as a means of assisting first time buyers. Were planning policy to act as an inducement to deliver more retirement housing, the range of builders entering the market, and in turn the diversity of choice available to older home buyers, would kickstart a renaisance in the retirement sector.

The typical retirement providers argue using official data that they make an average planning contribution of £6,285 compared to £33,000 per unit across all units.[61] However, this is only after costly and time consuming arguments with officials who try to treat retirement homes as if they were standard properties. There is a clear argument that even if some payments are retained, the current system needs to change to make clear that planning officials and councils should not treat retirement housing as if it was similar to other homes.

In the long run, this should help save the public purse serious sums of money – if for example we managed, over the next five years, to increase the number of owner-occupied retirement housing units being built to 30,000 a year, this would save £126 million in the first year, and £1.26 billion by year 10, given the HCA figure of £3,500 in health and social care costs per person per year.[62]

In addition, it would help give people a greater feeling of control in their life, by giving them access to a home that was suited to their needs. As was noted earlier, retirement housing's share of total housing in the the UK is almost ten times smaller than in other, similar countries, so there is clearly a structural failure in terms of providing what people would like.

61 Retirement figures relate to average yearly planning contributions made by members of the HBF who are retirement providers, taken from data over the last two years. Mainstream figures are calculated by dividing the £6 billion of planning contributions made in the year by the total 2016/17 new build housing starts of 183,570 (HBF numbers).

62 Assumes 1.2 people living in each retirement unit, which is then multiplied by the number of units and the HCA's figure of £3,500 per person saved each year in health and social care costs.

Conclusion

Social care is that most intractable of political dilemmas: a subject which requires a degree of consensus but which is also urgent, complex, and emotionally charged.

The easiest solution politically is to say that everything must be free at the point of use, and that the funding to pay for this can come from "the rich" (defined by everyone as someone richer than them). But the financial mathematics simply do not add up. Nor would the system be particularly fair – as even the most spendthrift socialist cannot seriously believe that it is the job of the state to pay for fully equipped gyms and bistro bars in every care home.

This report sets out a way to establish a system that provides more money and spends it well; is fair across generations and for each individual; and increases competition and the supply of care and retirement housing. The exact level at which the Universal Care Entitlement would be set, or of what each of the tiers of the Care Supplement provides, would need to be carefully calculated by the Government and insurance industry respectively – but I am confident that we can make it work.

Politicians on all sides have a duty to behave responsibly on this matter. In return, the Government in its forthcoming Green Paper needs not only to set out the options but at least give some indication of a preferred set of solutions.

I am of course conscious that the current parliamentary arithmetic means that a solution is difficult to achieve in this Parliament. But we need to stop avoiding this issue.

Ultimately, the key to reaching a solution on this issue is fairness. Simply increasing taxes on the working age population will be unfair to the young, who will end up paying for the care of several generations. Equally, simply asking the "comfortable elderly" to pay for themselves, when they have organised their affairs without being told this would be happen, would be unfair to them.

"Those without the money to pay the insurance premium, or who decide not to pay, will still benefit from the Universal Care Entitlement."

Any policy which aims to be stable for the long term needs to steer between these rocks of generational unfairness.

The system proposed here will guarantee a fair Universal Care Entitlement for all with a system that has significantly more public funding. It will then inject more money through the Care Supplement for those who want to top this up, and do so in a way that relieves the stress and worry that is currently built into the system. Finally, it will ensure that there is an increase in the supply and quality of care homes and retirement housing, reducing the cost of social care to both the state and individuals.

Those who are already above working age will have been given the chance to take out an insurance policy, paid in the vast majority of cases out of housing wealth, which means that they will not have to make any further contribution from their assets. Those without the money to pay the insurance premium, or who decide not to pay, will still benefit from the Universal Care Entitlement.

> **"This system rewards personal responsibility and gives people the chance to see the benefit of saving intelligently."**

This mix of funding ideas, along with the other policy suggestions outlined above, meets the key principles set out at the start of this paper. It provides a better safety net for all than is currently on offer.

It rewards personal responsibility and gives people the chance in their final years to see the benefit of saving intelligently. It allows people to know that they have been able to pass a significant inheritance on to their children, if they have the chance to do so. Above all, both the Universal Care Entitlement and Care Supplement offer the peace of mind that people crave.

This debate has been unresolved for too long – and the problem will only get more acute as time passes. It is time to act.