Fixing Social Care

The Fundamental Choices

By Jethro Elsden and Alex Morton

About the Authors

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About the Centre for Policy Studies

The Centre for Policy Studies was recently named as the most influential think tank in Westminster in polling of Conservative MPs by ComRes. Its mission is to develop policies that widen enterprise, ownership and opportunity, with a particular focus on its core priorities of housing, tax, business and welfare.

Founded in 1974 by Sir Keith Joseph and Margaret Thatcher, the CPS is primarily responsible for developing a host of successful policies, including the raising of the personal allowance, the Enterprise Allowance, the ISA, transferable pensions, synthetic phonics, free ports and the bulk of the Thatcher reform agenda.

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Fixing Social Care

In the wake of the coronavirus, fixing the elderly care system is more urgent than ever.

This report examines the three main options for reform: Dilnot-style insurance, full state funding, or a hybrid system modelled on the state pension.

It evaluates them on the basis of cost, political feasibility and whether they will help expand provision to meet ever-growing demand. It also studies the lessons from other countries.

Dilnot is by far the cheapest option, but this also makes it the least attractive politically, due to regional inequalities and the fact that people will have to sell their homes.

It concludes that the state 'pension-style' - with a set level of care from the state, topped up by individuals - is the most attractive. It eliminates the risk of selling homes, incentivises the provision of more care facilities and retirement housing, and most resembles the best overseas systems.

However, it stresses that there are no perfect answers, and that any solution will involve higher spending and uncomfortable tradeoffs.

Introduction

The social care sector has been battered during the coronavirus crisis.

As of July, early data indicates that more than one in 20 care home residents in the UK had been killed by the virus.[1] The UK is not alone in seeing its care home sector be badly hit by the pandemic – many countries have had a similar or larger proportion of deaths occur there. But the crisis has highlighted once again how badly reform of the sector is needed – and made it an even more urgent political imperative. Improving the quality of care, as well as how to pay for it, is an absolute necessity.

The issue of social care for the elderly has, of course, been central to the political debate for some years. It was at the heart of the failed 2017 Conservative manifesto.[2] It was also something that Boris Johnson promised to fix when he became Prime Minister in 2019, pledging to banish the spectre of having to sell the family home to pay for care.[3]

As this report shows, underfunding and a dysfunctional structure have left the sector with many issues, including an ageing stock of care homes, staff who are often paid too little and above all an inability to fully meet the demands for care from an ageing population. The issue has also become more politically toxic as more and more older people have required care, and they and their families have discovered how unfair the existing system of funding actually is.

"This report attempts to evaluate the main solutions that have been proposed to the issue of social care for the elderly (not least by this think tank), and explains the pros and cons of each."

With a Comprehensive Spending Review looming, the Government will need to set out not just how it will reform this sector, but how it will put it on a sustainable financial footing – and where the money will come from. This report attempts to evaluate the main solutions that have been proposed to the issue of social care for the elderly (not least by this think tank), and explains the pros and cons of each. We hope it will be useful not just to those working on this issue in government, but those who want to understand just why funding elderly care has become such a contested and controversial issue.

It is important to stress that this report focuses only on care for the elderly, not the social care system as a whole. The proposals also focus on the situation

1 International Long-Term Care Policy Network, 'Mortality Associated with COVID-19 Outbreaks in Care Homes: early international evidence' (LSE, 2020), p21. https://ltccovid.org/wp-content/uploads/2020/06/Mortality-associated-with-COVID-among-people-who-use-long-term-care-26-June-1.pdf

2 Conservative and Unionist Party, 'Forward, Together' (Conservative and Unionist Party, 2017). https://s3.eu-west-2.amazonaws.com/conservative-party-manifestos/Forward+Together+-+Our+Plan+for+a+Stronger+Britain+and+a+More+Prosperous....pdf

3 Johnson, Boris, 'Boris Johnson's first speech as Prime Minister: 24 July 2019' (GOV.UK, 2019). https://www.gov.uk/government/speeches/boris-johnsons-first-speech-as-prime-minister-24-july-2019

in England, as care is a devolved issue, though the principles apply to other parts of the UK as well.

A key starting point for the purposes of this paper is that the elderly care system is already significantly underfunded – a joint report by the House of Commons Health and Local Government Select Committees in 2018 predicted the funding gap of £2.2 to £2.5 billion in 2019-20, although the Government has since injected more funding.[4]

> **"A key starting point for this paper is that the elderly care system is already significantly underfunded."**

In his Centre for Policy Studies paper 'Fixing the Care Crisis', the Rt Hon Damian Green MP showed the inexorable demographic pressures the care system is under.[5] Furthermore, cost pressures will rise as the population ages. However, the pressures depend partly upon the solution that we choose.

Care is also becoming ever more politically salient. Rising asset values (especially house prices) and a freeze on the threshold for state support since 2010/11 have meant that more and more people have become ineligible for state support and have seen a greater and greater share of their assets being eaten up by the cost of care. For the small number who end up with very extensive care needs for a protracted period of time,[6] this means losing much if not most of their savings, often including having to sell their home in order to fund the cost of their care.

In order to safeguard the value of their assets and leave something to pass on to their children, many people might be persuaded to take out insurance against the risk of catastrophic end-of-life care costs. Unfortunately, it is precisely because a small number of people will suffer extremely high care costs that no insurance market exists. This is the 'tail risk' problem: insurers are reluctant to enter the care market, because their liabilities in caring for that small number of people will jeopardise any profit to be made in covering the rest of the pensioner population. No country in the world has solved this conundrum. Therefore, despite being one of the most financially devastating prospects that a person can face in their life, social care remains one of the few uninsurable risks.

This situation has been exacerbated by the way care is funded. Local authorities bear the full cost of care for anyone in their area who applies and qualifies for state support. Given the significant budget cutbacks since 2010, many local authorities have chosen to tighten up eligibility criteria.[7] Since 2010, the number of requests for social care has increased, and yet fewer older people now receive publicly funded social care.[8]

4 Health and Social Care Select Committee and the Housing, Communities and Local Government Select Committee, 'Long-term funding of adult social care' (House of Commons, 2018), p10. https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/768/768.pdf

5 Green, Damian, 'Fixing the Care Crisis' (Centre for Policy Studies, 2019). https://www.cps.org.uk/research/fixing-the-care-crisis.

6 The Dilnot Commission included analysis from the Personal Social Services Research Unit (PSSRU) to show that about 10% of the over-65s would have care costs of more than £100,000. See Forder, Julien and Fernandez, Jose-Luis, 'Analysing the Costs and Benefits of Social Care Funding Arrangements in England: Technical Report' (PSSRU, 2012). https://www.pssru.ac.uk/pub/dp2644-3.pdf#page=29.

7 Watt, Toby, Varrow, Michael, Roberts, Adam and Charlesworth, Anita, 'Social Care Funding Options' (The Health Foundation and The King's Fund, 2018). https://www.health.org.uk/sites/default/files/Social-care-funding-options-May-2018.pdf.

8 Independent Age and Institute and Faculty of Actuaries, 'Will the Cap Fit?' (Independent Age and Institute and Faculty of Actuaries, 2017). https://www.actuaries.org.uk/system/files/field/document/WIll-the-cap-fit.pdf#page=10.

In general, care provided in people's own homes ('domiciliary care') is funded by the state, unless the individuals concerned have more than £23,250 in assets apart from the main family home or an income above £9,828.[9] If someone has an income above this, they will have to contribute from that point, but the council will top up the rest. So for example, if you had an income of £12,000 a year, and care needs that cost £7,000 a year, you would have to contribute the first £2,172 and the council would contribute the remainder. The criteria for care homes ('residential care') are broadly similar, but this time people can be asked to sell their homes if their partner is not still living there.

In recent years, those paying for their own care (self-funders) have come to be charged much higher fees in order to cross-subsidise local authority residents. One consequence is that investment in the sector has been concentrated where there are sufficient numbers of self-funders: areas where care home residents are mainly local authority funded have been deprived of investment and new care home facilities and capacity.

In terms of the state's contribution, government spending on social care has lagged behind demand since as far back as 2005/6.[10] The recent increases in funding for social care announced by the Government have helped to shore up the sector in the short term, but they are only a stop-gap measure.[11] Demographic change means social care needs will rise, with the number of people aged over 65 set to increase by almost two million by 2030.[12] And this ignores the increasing amount of unmet demand that now exists.

> **"Government spending on care for the elderly has lagged behind demand since at least 2005/6."**

According to the 2018 Health Survey for England, while 27% of the over-65s surveyed said they needed help with activities of daily living in the last month, only 11% said they had received help.[13] Age UK estimates that there are now about one and a half million people aged over 65 with unmet care and support needs, and this has grown sharply in recent years.[14] Some of this is driven by demographic change, but a large part is due to the failure of the UK's social care system to ensure that supply keeps up with rising demand. These problems are compounded by the high turnover and vacancy rates in the social care sector, which interfere with the quality of services and increase training and recruitment costs.[15] There is a clear need for a long-term funding settlement in social care.

9 AgeUK, 'Paying for homecare' (AgeUK, 2020). https://www.ageuk.org.uk/information-advice/care/paying-for-care/paying-for-homecare/

10 The Actuarial Profession, 'Where Next for Care?' (October 18, 2011). https://www.actuaries.org.uk/system/files/documents/pdf/andrew-dilnot-presentation.pdf#page=5.

11 King's Fund, 'What does the 2020 spring Budget mean for health and care?'(King's Fund, 2020). https://www.kingsfund.org.uk/blog/2020/03/spring-budget-mean-health-and-care

12 Office for National Statistics, 'Population of State Pension Age and Working Age, and Old Age Dependency Ratios, for Local Authorities and Regions in England'. https://www.ons.gov.uk peoplepopulation andcommunity/population andmigration/populationprojections/datasets/populationofstatepensionageandworkingageandoldagedependencyratiosforlocalauthoritiesandregionsinengland

13 NHS Digital, 'Health Survey for England: Data Tables', Table 4: 'Social care for older adults'. https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2018/health-survey-for-england-2018-data-tables.

14 Age UK, 'Estimating Need in Older People' (Age UK, 2019). https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/active-communities/id204303-estimating-needs-report.pdf.

15 National Audit Office, 'Adult Social Care at a Glance' (National Audit Office, 2018). https://www.nao.org.uk/wp-content/uploads/2018/07/Adult-social-care-at-a-glance.pdf#page=31.

This report reviews the spectrum of options according to three key criteria:

1. The cost of any reform proposal
2. The political feasibility of any reform proposal
3. How it will ensure a greater supply of care and increase productivity.

"One of the most scandalous statistics unearthed by the CPS's report with Damian Green was that the productivity of the care sector has actually gone down by almost 20% since 2000 – the equivalent of cutting budgets by £3.4 billion."

All three of these should be fairly self-explanatory. Any reform that is introduced must be affordable. It must be politically feasible, especially with the spectre of the 2017 election hovering over proceedings. And it must put the care sector on a more stable footing by ensuring that it is able to deliver more capacity and efficiency without relentless increases in cost. Productivity is key to this: one of the most scandalous statistics unearthed by the CPS's report with Damian Green was that the productivity of the care sector has actually gone down by almost 20% since 2000 – the equivalent of cutting budgets by £3.4 billion.[16]

There have, understandably, been many proposals made for reform, and many attempts to weigh up their contrasting merits. (See for example, this report from the King's Fund.[17]) We have chosen to focus on the three models which appear to command the greatest interest within Whitehall, and typify the main approaches.

The first is an insurance model as advocated by the Dilnot Commission[18] – where most people pay for their social care via private insurance, but costs are capped and the state steps in once a person has spent a certain amount of their own money on their care. We term this the 'cap and insurance' model.

At the other end is the state taking on full responsibility for funding social care: effectively, the social care system adopts the NHS model, with care free at the point of use, and the system funded out of general taxation. We term this the 'state funding' option. The particular variant we have used for comparative purposes is that advocated by Policy Exchange in its report on social care in the 21st century[19] – but there are many others we could use. It is important to stress that this variant would only see funding nationalised: private providers would remain involved in the industry. However, alternatives have been proposed, not least by the Labour Party, in which the state takes over completely.

The third model we examine sits between these two poles: the state guarantees a reasonable level of care, but above this, individuals must pay for additional services themselves – particularly additional costs in terms of more desirable accommodation or services such as (non-urgent) physiotherapy.

16 Green, Damian, 'Fixing the Care Crisis' (Centre for Policy Studies, 2019), p15. https://www.cps.org.uk/research/fixing-the-care-crisis.

17 Wenzel, Bennett et al, 'Approaches to Social Care Funding' (King's Fund, 2018). https://www.kingsfund.org.uk/publications/approaches-social-care-funding

18 Dilnot Commission, 'Fairer Care Funding: The Report of the Commission on Funding of Care and Support' (Dilnot Commission, 2011). https://webarchive.nationalarchives.gov.uk/20130221121534/http://www.dilnotcommission.dh.gov.uk/our-report/

19 Lightfoot, Warwick, Heaven, Will and Henson Gric, Jos, '21st Century Social Care' (Policy Exchange, 2019). https://policyexchange.org.uk/publication/21st-century-social-care/.

This was the system proposed by Damian Green in his CPS report,[20] with the explicit inspiration being the state pension, where there is a successful blend of universal state provision and individual contribution. We therefore call this the 'pension-style' since like that system, it relies on a basic level for all, topped up by those who want to do so. The core level of care and entitlement would be termed the National Care Entitlement, as it would be available to all who needed it.

> **"The system that is most likely to boost supply is the 'pension-style', which replicates both overseas successes and the UK model in the 1980s, which saw a massive expansion of care home facilities."**

Of course, it is important to stress that there is a huge range of further options and variants. For example, rather than having the cap suggested by the Dilnot Commission, which does not cover living or accommodation costs, the Government could opt for an all-inclusive cap of £100,000, as suggested by Independent Age and the Institute and Faculty of Actuaries.[21] This does a better job of protecting people's assets and many more people will benefit from it, but it is more expensive.

However, grouping together the proposed solutions in the way that we have allows us to examine the strengths and weaknesses of each option. And the most important point to make is that none of them is perfect. When it comes to social care, there are no ideal solutions, only tradeoffs.

A Dilnot-style capped cost reform is the cheapest and ensures that young people do not get burdened with the responsibility of paying for social care for older people, but offers much less comprehensive support and is hard to square with guarantees that no one will have to sell their home. For the other proposals, the tradeoff is reversed: both offer more comprehensive protection against catastrophic care costs and both pass the test of ensuring that no one should have to sell their home. But both will be much more expensive than Dilnot-style reform, with the state taking on full responsibility the most expensive.

The system that is most likely to boost supply is the 'pension-style', which replicates both successful systems overseas and the model in the UK in the 1980s, which saw a massive expansion of care home facilities. By guaranteeing a payment but without creating a monopoly and relying on NHS funding (which risks social care becoming the next public or mental health, starved of funding to pay for the biggest cost – acute care), this model should help deliver more and better care provision both in homes and in residential settings.

To govern is to choose, and the Government is going to have to pick one of these models as the basis for reforming social care. Based on the international evidence and the three criteria examined in this report – cost, political feasibility and increasing supply – we believe that the Green/CPS model is the strongest (as indeed could be expected, given its provenance). However, we hope that even

20 Green, Damian, 'Fixing the Care Crisis' (Centre for Policy Studies, 2019). https://www.cps.org.uk/research/fixing-the-care-crisis.

21 Independent Age and Institute and Faculty of Actuaries, 'Will the Cap Fit?' (Independent Age and Institute and Faculty of Actuaries, 2017). https://www.actuaries.org.uk/system/files/field/document/WIll-the-cap-fit.pdf.

Table 1: Three models compared – cost, political feasibility and increase in supply

	Cost	Political feasibility	Increase in supply
Cap and insurance			
Pension			
State funding			

for those who disagree with our verdict, this report serves its purpose of setting out the strengths and weaknesses of the options, and the tough choices that ministers will have to confront.

Whatever the model that Government chooses, they have to put in place a reformed system now, ahead of a long-term Spending Review, so that the Department for Health and Social Care can begin to translate this into a well functioning and operating system in the next few years. This country cannot afford further delay.

International comparisons

Before we explore home-grown suggestions for solving Britain's care crisis, it is worth pausing to consider how other countries do it, and what lessons we should apply when bringing in reforms in the UK.

There is no one solution we can import, but there are points to learn we should take account of.

Long-term social care for older people is a problem across the entire developed world – demographic change is impacting all such societies, from Japan to the United States. Yet the first and most obvious thing to note is that the current social care system in England compares poorly with most other countries. Most other developed nations – such as France, Germany, Japan and the Netherlands – introduced reforms many years (or in some cases decades) ago.

To quote a report by Incisive Health, commissioned by Age UK: 'How do we compare? Rather badly, is the honest answer. Here we arguably get the worst of many of the different elements… partly because no government is yet to really grip the issues.'[22]

It is also clear that the sooner we grasp the nettle and make changes, the sooner we can solve the issues that bedevil our system. As the same Incisive Health report emphasises, a key lesson from Japan is that 'the sooner you embrace the challenge of increasing and improving social care to meet the needs of an ageing population, the sooner you start to overcome it'.[23] The moment for reform is now, not tomorrow.

> **"Long-term social care for older people is a problem across the entire developed world – demographic change is impacting all such societies, from Japan to the United States."**

But what form should that reform take? Here the evidence is unfortunately less clear cut. While some nations have better systems than others, there is no magic bullet – no single system is the stand-out performer and all of them come with tradeoffs.[24]

However, a few clear findings emerge. First, most countries use both public and private systems to pay for social care costs. But few countries use private insurance to pay for the bulk of care costs. Where this is the case (as in the US), plans tend to be expensive and accessible mostly only by the well-off. Instead, it generally tends to be used to complement social insurance schemes as a way to share costs between the state and the individual. This is the

22 Incisive Health, 'An International Comparison of Long-Term Care Funding and Outcomes: Insights for the Social Care Green Paper' (Incisive Health, 2018).: https://www.incisivehealth.com/wp-content/uploads/2018/08/international__comparison__of__social__care__funding__and__outcomes.pdf.

23 *Ibid.*, p2.

24 *Ibid.*

situation in France, Germany, Ireland, Japan and South Korea. And of these countries, only France has a private insurance market of considerable size, with 15% of over-40s having private social care insurance – in comparison, the figure in the UK is just 0.05%.[25]

The development of a large, functioning private insurance market to do the heavy lifting in paying for social care is a key part of the 'cap and insurance' family of reforms, such as the Dilnot proposal. Unfortunately, the international evidence suggests that even when lifetime care costs are capped – neutralising the 'tail risk' problem – such an insurance market is unlikely to develop.

There is more of a precedent for private insurance in a more mixed model whereby people buy private insurance as a complement to basic social care paid for by the state in order to top up their care, in line with the CPS model. This is very similar to the model in Germany – the state provides basic care via a social insurance scheme; people then buy out-of-pocket top ups, which they can use to purchase private insurance policies to cover additional and desirable elements of social care.[26] This model works well and has helped to share the costs of social care in a reasonably clear and fair manner.

Another lesson from overseas is that simply having the state pay for all or most of social care comes with its own risks – because demographic pressures tend to make such systems unsustainable. Countries such as Japan and Scotland, which originally introduced universal free personal care, have seen costs spiral and have been forced to reduce eligibility and cut back care packages.[27] Of the many countries with social insurance schemes for social care, only Germany's is in good financial condition, and that is only because it increased contributions in 2008 – and because individuals can top up their contributions, as mentioned above. All other countries have faced challenges in ensuring contributions match the cost of provision.

"The development of a large, functioning private insurance market to do the heavy lifting in paying for social care is a key part of the 'cap and insurance' family of reforms, such as the Dilnot proposal."

This is one of the key weaknesses of proposed reforms in which the state takes on responsibility for funding all social care costs, or (as in the Policy Exchange report) all apart from a small co-payment: that it leads to a big increase in demand, and hence costs. There is also the perennial danger that, in a competition between departments for scarce funding, social care will lose out – as it all too often has in recent decades. Of course, the 'pension-style' suffers from a similar problem, in that you have to put more money into the system to guarantee that set standard of care, but this is at least capped more openly and transparently.

25 Robertson, Ruth, Gregory, Sarah and Jabbal, J, 'The Social Care and Health Systems of Nine Countries' (The King's Fund, 2014). https://www.kingsfund.org.uk/sites/default/files/media/commission-background-paper-social-care-health-system-other-countries.pdf#page=13.

26 However, in the German system, people can opt out of the public scheme and use private insurance to pay for social care if they wish. Furthermore, unlike in the CPS proposal, accommodation costs are not covered and people are expected to cover these costs themselves.

27 Dilnot Commission, 'Fairer Care Funding: The Report of the Commission on Funding of Care and Support' (Dilnot Commission, 2011). https://webarchive.nationalarchives.gov.uk/20130221121529/https://www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf#page=31.

The third vital point is that most countries cover care in the medical sense – but not accommodation and living costs for those living in care homes. This means that individuals in residential care still have pretty substantial costs to meet. In Japan, for example, accommodation was originally covered by the state, but by 2005 it had become too financially costly and so was dropped.[28] On this score, the Dilnot proposal is most in line with the international evidence.

In summary, the international evidence suggests that a large private insurance market for comprehensive social care insurance is unlikely to develop, but a smaller insurance market to complement state-funded basic care might well arise given the right conditions. Additionally, countries where the state has provided full free social care without restrictions on cost have seen costs spiral unsustainably and have been forced to restrict eligibility and cut back services. And although there is a lot of variation in how countries fund and deliver social care, there is no stand-out system – all of them come with their own tradeoffs and issues.

28 Robertson, Ruth, Gregory, Sarah and Jabbal, J, 'The Social Care and Health Systems of Nine Countries' (The King's Fund, 2014). https://www.kingsfund.org.uk/sites/default/files/media/commission-background-paper-social-care-health-system-other-countries.pdf#page=13.

1. The Models Compared – Cost

Whichever reform the Government chooses to go forward with, it is going to be expensive.

Even a Dilnot-style cap system would require several billion pounds of extra spending initially, and that cost would steadily rise as the number of older people in need of care rose over the coming decades.

This may be difficult for government to stomach, particularly given how much pressure the public finances are already under. But the costs of not acting now are simply too great – and will rise the longer reform is put off. In particular, we need to give the sector the certainty it needs to invest, in order to increase capacity. If not, the system will need billions more in emergency funding from central government, and many more people will be forced into the position of having to sell their home to fund their social care.

However, it is also the case that every pound the Government spends on social care will ultimately come from taxpayers' pockets. It is therefore important to ensure that whichever reform option is chosen, it provides the best value for money, both immediately and over the years to come.

In terms of the drivers of increasing cost, the most obvious is age. Analysis from 2018 estimated that the number of people aged over 65 who need help with daily activities (i.e. are unable to perform at least one instrumental activity of daily living or have difficulty performing one activity of daily living without help) is likely to increase by 67% between 2015 and 2040 and 116% between 2015 and 2070 – from 3.5 million in 2015 to 5.9 million in 2040 and 7.6 million in 2070.[29]

"This may be difficult for government to stomach, particularly given how much pressure the public finances are already under. But the costs of not acting now are simply too great – and will rise the longer reform is put off."

But different reforms have different costs. It is not as straightforward as simply considering how much more per person the state may need to pay out for care – reforms will have second-order effects, most notably by changing demand and incentives throughout the system.

When free personal care was introduced in Scotland in 2002, for example, it led to a significant and unexpected increase in demand. By 2005, demand for domiciliary and residential care had increased by 62% and 29% respectively – driven in part by the emergence of unmet need from people who previously paid for care services themselves or just relied on the Attendance Allowance.[30]

29 Wittenberg, Raphael, Hu, Bo and Hancock, Ruth, 'Projections of Demand and Expenditure on Adult Social Care 2015 to 2040' (Personal Social Services Research Unit, 2018). https://www.pssru.ac.uk/pub/5421.pdf#page=7.

30 Bell, David, Bowes, Alison and Dawson, Alison, 'Free Personal Care in Scotland: Recent Developments' (Joseph Rowntree Foundation, 2007). https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/2075-scotland-care-older-people.pdf#page=7.

Reform may also have secondary impacts that reduce other costs on the state, such as easing the burden on the NHS, where older patients often see their discharge delayed due to difficulties in arranging care packages. The National Audit Office estimated in 2016 that these delays cost the NHS about £820 million every year.[31] If reform of the social care system makes the system better at putting care in place for those who need it, and hence reducing delays in discharge, this will save money. There would also be a substantial benefit to patients otherwise forced to spend more time in hospital than they need, potentially losing their mobility and ability to do simple tasks such as dressing or bathing.[32] Similarly, reforms that increase the supply of domiciliary care and specialist retirement housing will be cheaper, more effective and more popular than those which end up pushing more people into residential care homes.

So how do our three broad options compare?

The proposal for a cap on lifetime care costs, as laid out in the report of the Dilnot Commission,[33] and taken forward in the 2014 Care Act, is likely to be the cheapest of the three reform proposals examined in this report.

For example, the Department of Health and Social Care asked the Personal Social Services Research Unit (PSSRU) to cost the proposed £72,000 cap for a report published in 2015.[34] It estimated that the reforms would increase public expenditure by 2030 by roughly £2.5 billion (updated for 2020 prices). A more recent estimate by The Health Foundation in 2019 costed an updated version of Dilnot at about £1.7bn today, rising to £2.1bn by 2023/24.[35]

"The calculations above use the level of lifetime cap proposed in the 2014 Care Act, which updated for inflation stands at about £78,000."

There are two key variables when it comes to the cost of a Dilnot-style system – the cap and the floor. The cap is how much any one individual will ever be asked to pay. The floor is the asset value protected from contributions; contributions are taken between the floor and the cap. In the original Dilnot proposal, this included the family home, but it would be possible to exclude it – although that would obviously hugely privilege those in the affluent South-East.

The calculations above use the level of lifetime cap proposed in the 2014 Care Act, which updated for inflation stands at about £78,000. This would still mean, for most people, care costs would be substantial. In addition, the cap would likely exclude all accommodation costs (if in line with the original Dilnot proposal).

31 Comptroller and Auditor General, 'Discharging Older Patients from Hospital' (National Audit Office, 2015). https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf#page=9.

32 *Ibid.*

33 Dilnot Commission, 'Fairer Care Funding: The Report of the Commission on Funding of Care and Support' (Dilnot Commission, 2011). https://webarchive.nationalarchives.gov.uk/20130221121534/http://www.dilnotcommission.dh.gov.uk/our-report/.

34 Wittenberg, Raphael and Hu, Bo, 'Projections of Demand for and Costs of Social Care for Older People and Younger Adults in England, 2015 to 2035' (Personal Social Services Research Unit, 2015). https://www.pssru.ac.uk/pub/DP2900.pdf#page=7.

35 Alderwick, Hugh, Tallack, Charles and Watt, Toby, 'What should be done to fix the crisis in social care: 4: see the capped cost model as a flexible approach to reform' (The Health Foundation, August 30, 2019). https://www.health.org.uk/news-and-comment/blogs/what-should-be-done-to-fix-the-crisis-in-social-care/4-see-the-capped-cost.

Any lower cap would be politically more attractive, but would also cost more. For example, lowering it to £46,000 would increase the initial cost to £2.6bn, rising to £3.1bn by 2023/24. A cap of zero – in which the state covered care, while you only paid for living costs – would cost £7.8bn by 2023/24.[36] That is a static estimate that does not take account of any boost to demand that would occur or the extra money needed to improve quality and access. Once you consider these factors, then the total cost of the reform could conceivably head towards the £10 billion mark.

In other words, the reason why Dilnot costs much less than the other two proposals assessed in this report is that it does not protect individuals' assets to anything like the same extent. Because the cap is not all-inclusive, those with high care needs would still be required to spend large amounts of their own money in order to fund aspects of their care, such as living costs. To quote Independent Age and the Institute and Faculty of Actuaries: 'Without an all-inclusive cap, individuals with the highest care needs will continue to see their costs rise to well over £100,000.'[37] The same report claims that the £72,000 cap set in the 2014 Care Act would benefit only 10% of those who pay for their own care.

Of course, this defect is easily remedied: you simply convert the cap into an all-inclusive cap, so that all costs – including living and accommodation fees – are covered once a person has spent a certain amount. Independent Age and the Institute and Faculty of Actuaries did just this when they suggested that the current system should be replaced by a £100,000 all-inclusive cap.[38]

This does a better job of protecting people's assets and many more people would benefit from it. But again, it is much more expensive, since you are in effect paying for all social care needs.

The state funding model, with or without a co-payment, and the 'pension-style' proposed by the CPS, make a much more comprehensive attempt to prevent people who need care exhausting most of their assets than the original Dilnot model. But they do this at a higher cost.

> **"A cap of zero – in which the state covered care, while you only paid for living costs – would cost £7.8bn by 2023/24."**

In the case of state funding, the government takes on full responsibility for funding social care (potentially with a minimal top up), while under the 'pension-style' it takes responsibility for a set level of free social care, above which individuals must fund extra care and services themselves.

It is difficult to calculate precisely how much each of these schemes would cost, because it is hard to know how much demand may rise by, and in the case of the CPS reform, where the threshold for free care would be set and how large a role private complementary insurance could play in carrying the burden of costs. However, Policy Exchange's calculations set out that in a worst-case scenario, nationalising funding might end up with an annual price tag of £11bn – the current level of private expenditure for domiciliary and residential care each year.[39]

36 *Ibid.*

37 Independent Age and Institute and Faculty of Actuaries, 'Will the Cap Fit?' (Independent Age and Institute and Faculty of Actuaries, 2017), p4. https://www.actuaries.org.uk/system/files/field/document/WIll-the-cap-fit.pdf.

38 *Ibid.*

39 Lightfoot, Warwick, Heaven, Will and Henson Gric, Jos, '21st Century Social Care' (Policy Exchange, 2019). https://policyexchange.org.uk/publication/21st-century-social-care/.

This may, however, be an underestimate, for two reasons.

First, at the moment, local authorities are spending too little per resident for care homes to cover their costs fully. This means that those care homes where most of the residents are funded by the local authority are finding it difficult to remain financially viable. The Competition & Markets Authority (CMA) estimates that about a quarter of care homes have 75% or more of their residents funded by the local authority, and in these homes the CMA calculates that the local authority is paying 10% below cost per bed. It estimates that the cost of this to the care home sector is between £200m and £300m across the UK – and given that England makes up the bulk of the UK, we can assume that the gap in England is probably above £200m.[40]

Unless this is remedied, these care homes are going to struggle to survive, let alone make new investment to increase capacity. Therefore, extra spending by the state is already necessary in order to make sure that the care home sector is viable – and without private self-funders, there will be no cross-subsidy, so the fees the Government pays out will have to be substantially higher than those that local authorities are currently paying.

Second, as we saw in Scotland, if these reforms are implemented, there will be a large increase in demand. There certainly appears to be a lot of pent-up demand, with Age UK estimating that there may be in the region of one and a half million older people who cannot get access to the care that they require.[41]

Therefore, it is highly likely that even if the state absorbs the full £11 billion that currently gets spent privately in the care sector, it will have to spend even more to keep the care sector viable and deal with a likely surge in demand. For example, say demand rises by 29% after the reforms – the level seen in Scotland in terms of residential care after 2002 – then it would turn the £11bn currently spent privately into just under £14bn of state spending.

“The Competition & Markets Authority (CMA) estimates that about a quarter of care homes have 75% or more of their residents funded by the local authority, and in these homes the CMA calculates that the local authority is paying 10% below cost per bed.”

It should be noted that Policy Exchange’s version of a nationalised system would include a co-payment of up to £5,000 a year. This should act as a disincentive to some degree; however, it is means-tested so that only those with an income over £27,000 would have to pay anything, meaning that many people would either not have to pay anything or face a negligible fee.

The problems above also apply to the CPS proposal, which is also likely to be significantly more expensive than a Dilnot-style cap. In the original Green/CPS paper, the cost was estimated at £2.5bn a year, but this did not include the existing underfunding or pent-up demand, and also assumed that all current private spending within the system would continue.[42]

40 Competition & Markets Authority, ‘Care Homes Market Study: Final Report’ (Competition & Markets Authority, 2017), p13. https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf

41 Age UK, ‘Estimating Need in Older People’ (Age UK, 2019), p9. https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/active-communities/id204303-estimating-needs-report.pdf

42 Green, Damian, ‘Fixing the Care Crisis’ (Centre for Policy Studies, 2019). https://www.cps.org.uk/files/reports/original/190426143506-DamianGreenSocialCareFinal.pdf#page=20.

One of the flaws of a state funding or penion model is that for some people it effectively either fully displaces (state funding) or partially displaces (pension) existing private spending with public subsidy. Its ultimate cost is therefore likely to be significantly higher.

Under the 'pension-style', the state provides a set level of service – funded by taxation in the CPS model, or by social insurance in countries such as Germany. Then, if people want to upgrade to a better care home, or larger room, or more frequent domiciliary visits or visits by a physiotherapist where this is not strictly necessary for them, they fund it themselves.

Under the CPS proposal, people already receiving social care would maintain their existing arrangements, and only those newly entering the social care system would qualify for the 'National Care Entitlement' (the equivalent of the state pension).[43] This means that it will take time, probably a few years, for the entire social care system to be covered, meaning that the build-up in cost will be more gradual. Once this process is complete and all old arrangements have expired, it will be offering basic social care free at the point of use to anyone who meets the eligibility criteria.

This is obviously more expensive than a Dilnot-style system. But compared with reforms where the state takes on full responsibility for social care funding, it will be less costly. The extent to which this is the case would depend on the level at which state provision is set – the Green paper used the definition for acceptable care produced by the relevant Commons committees – and the extent to which a top up market can be stimulated. Perhaps the most important variable is how much the National Care Entitlement covers in terms of accommodation costs: a more generous NCE that makes room for physiotherapy, exercise classes etc will end up costing more than one which essentially covers room, utilities and food.

"The larger the share of spending provided by top ups, the lower the cost to the state. For example, in Germany, about 3.3 million people now have supplemental social care insurance, and this is a figure that has been growing rapidly."

The generosity of the NCE also affects the extent to which an insurance market can develop. The larger the share of spending provided by top ups, the lower the cost to the state. For example, in Germany, about 3.3 million people now have supplemental social care insurance, and this is a figure that has been growing rapidly. Premiums total about 950m euros a year.[44] This money is not just saved by the state, but helps foster investment in the sector.

Assuming that the NCE is set in line with current estimates for decent provision, and a top up market develops among the middle classes, the 'pension-style' is highly likely to be cheaper than full state funding while remaining significantly more expensive than Dilnot, meaning a likely cost of between £5 billion and £8 billion

43 This was originally called the Universal Care Entitlement.

44 See Nadash, Pamela and Evans Cuellar, A, 'The emerging market for supplemental long term care insurance in Germany in the context of the 2013 Pflege-Bahr reform', Health Policy, vol 121, no 6, pp 588–93. https://www.sciencedirect.com/science/article/pii/S0168851017300672. The 950m euro figure comes from the authors' own calculations. The German Government began subsidising supplemental social care insurance in 2012 so there are now about 683,000 policies that pay lower premiums because of this – they pay an average annual premium of 260 euros. Plus, there are about 2.6m people paying non-subsidised annual premiums at an average of 300 euros. Added together, total premiums from these two groups equal about 950m euros.

depending on how generous the NCE is and how far it induces new demand.

In terms of secondary impacts, all three models would improve the situation in terms of delayed discharges, which currently cost the NHS about £820m every year.[45] It is likely that both the state funding and CPS proposals would help more in this regard since, as outlined later in this report, it is expected that they would boost supply in the sector more than the Dilnot-style cap reform would – but in all cases, there would be greater certainty for care homes about money being available to fund the patients, incentivising them to increase supply.

It is however difficult to estimate exactly how much of the £820m the NHS might be able to save, in particular if whatever reform is brought in leads to a boost in demand for residential care, and it continuing to outstrip supply.

The verdict

A cap on lifetime costs along the lines of the Dilnot proposal would be considerably less expensive than the other two proposals and therefore is best in terms of cost.

However, the tradeoff is a system that offers substantially less extensive help than the other proposals and does less to solve the fundamental issue of individuals seeing much of their wealth used up because of the cost of care.

Both state funding and a 'pension-style' would be expensive, but due to its explicit limits on the quantity and quality of care that the state would pay for, and the greater contribution from private funding, it is likely that the latter would be cheaper than the former. Therefore, we assess Dilnot as the most cost-effective, with the basics plus top up model next, and finally full state funding as the least effective.

Table 2: The three models compared – cost

	Cost
Cap and insurance	
Pension	
State funding	

45 Comptroller and Auditor General, 'Discharging Older Patients from Hospital' (National Audit Office, 2015). https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf#page=9.

2. The Models Compared – Feasibility

As well as being affordable, it is essential that any proposals are acceptable to the public and MPs – if not completely, then at least enough to get reform through and bed the system down.

An issue on this front is that the public appear to have a very poor understanding of how social care is currently funded. Many people seem to be under the misapprehension that it is essentially part of the NHS, and that the state should or will provide some (or in some cases all) of the care that they require, free at the point of use, because they have already paid for it via their taxes.[46]

There is also a common view that if this is not already the case, it probably should be. To quote a report by The Health Foundation and The King's Fund: 'Most people in our deliberative events favoured the idea of the state having most responsibility for funding social care. The National Centre for Social Research's British Social Attitudes survey found that most people (55%) favoured options where responsibility was shared, namely "means tested" (30%) and "means tested and capped" (25%), whereas 41% favoured "the Government (paid for by taxes)".'[47]

> **"While people clearly grasped that the state could not pay for everyone or everything, polls showed a clear feeling that the state should be the main funder of core needs."**

When this was drilled down into, the grasp of means testing appeared to mean more that people felt that the richest should make some contribution rather than a general belief that only the poorest should be supported.

To quote the same report: 'People were often shocked when the details of the means test were explained to them. The financial threshold was seen as very low and many people were unfamiliar with the idea that housing assets might be included in the assessment. The suggestion that housing would be taken into account provoked particularly strong negative emotions.'[48]

Thus while people clearly grasped that the state could not pay for everyone or everything, there was a clear feeling the state should be the main funder of core needs.

Separate polling shows that just 8% of voters oppose the idea that social care should be

46 Bottery, Simon, Varrow, Michael, Thorlby, Ruth and Wellings, Dan, 'A Fork in the Road: Next Steps for Social Care Funding Reform' (The Health Foundation and The King's Fund, 2018). https://www.kingsfund.org.uk/sites/default/files/2018-05/A-fork-in-the-road-next-steps-for-social-care-funding-reform-May-2018.pdf#page=30

47 *National Centre for Social Research's British Social Attitudes survey*, 2017

48 *A Fork in the Road: Next Steps for Social Care Funding Reform*. p30

provided free at the point of use – with near-universal support for the Government paying for it.[49]

There is, in other words, a spectrum of options on care that may be politically acceptable. But any move towards restricting the state's involvement purely to healthcare, and asking people to bear the full – or even main – costs of basic social care themselves, is likely to be a non-starter to say the least.

> **"Although care costs would be capped under Dilnot, people would still have to cover daily living costs, perhaps some £12,000 a year."**

This is one reason why all three of the models focused on in this report involve the state taking a larger role and paying more into the system, since this is what people think already happens. The Conservatives' proposals in the 2017 manifesto, for example, were actually more generous than those in the Dilnot report and arguably the current system – but because there had been so little public education on the subject, they were compared by the voters to an imaginary existing baseline of free care and no threat to the family home.

On which note, the other key test of whether a reform is politically feasible will be whether it ends the issue of people having to sell their home to fund the cost of their social care. As Boris Johnson said in his most recent comments on the topic, on June 30: 'We will end the injustice that some people have to sell their homes to finance the costs of their care while others don't.'[50] The Prime Minister has made this pledge several other times. Clearly, any reform that fails this test is unlikely to be taken forward.

In that regard, all three proposals discussed in this report are a big improvement on the current system. The pension and state funding models both make the guarantee absolute – though under the former, there will be an incentive for people to realise at least part of their housing wealth, perhaps post-mortem, to top up their care via insurance.

A Dilnot-style cap system would reduce the number of people who would be put in the situation of selling their home to pay for their care – but not eliminate the problem completely. Although care costs would be capped, people would still have to cover daily living costs, perhaps some £12,000 a year. Hence, someone paying £25,000 a year could, after living costs were deducted, see perhaps only £13,000 a year counted as care costs.

In this scenario it would take five and a half years for them to reach the cap, by which time they would have spent £137,500 on care.[51] That is a very large amount of money, and many people would have to sell their home to afford it. Furthermore, the number of people who would benefit from the cap, the centrepiece of the Dilnot reform, would not be that large – it is estimated that only 10% of people would reach it.[52]

49 YouGov/Independent Age Survey Results. https://independent-age-assets.s3.eu-west-1.amazonaws.com/s3fs-public/2018-08/Copy%20of%20Social%20Care%20Polling%20Results.pdf.

50 Johnson, Boris, 'PM Economy Speech: 30 June 2020' (GOV.UK, 2020). https://www.gov.uk/government/speeches/pm-economy-speech-30-june-2020.

51 Farley Dwek Solicitors, 'New Care Act 2014 – Cap on Care Costs' (Farley Dwek Solicitors, no date). https://www.farleydwek.com/new-care-act-2014-cap-on-care-costs/#:~:text=Under%20the%20new%20Act%2C%20it,care%20costs%20is%20%C2%A372%2C000.

52 That is, for people paying for their own care under the £72,000 cap in the 2014 Care Act. See Independent Age and Institute and Faculty of Actuaries, 'Will the Cap Fit?' (Independent Age and Institute and Faculty of Actuaries, 2017). https://www.actuaries.org.uk/system/files/field/document/WIll-the-cap-fit.pdf#page=4.

On the other hand, the Dilnot proposal does ensure that the burden of social care is not simply foisted on young people. In other words, for most people receiving social care, they would pay for it themselves rather than having the burden transferred to the general taxpayer – ie younger people still in work.

This is not the case for the 'pension-style' or state funding, which respectively envision some or almost all of the extra funding coming from those below retirement age. Damian Green's CPS paper, for example, proposed a range of options for funding the additional expenditure, but the one which received most attention was a hypothecated increase in National Insurance for those over 50. A nationalised system would see the cost absorbed by general taxation, which overwhelmingly falls on those of working age.

> **"Any proposal that essentially transfers the burden of paying for social care from older people to young people is likely to meet with some political opposition."**

This is important, since intergenerational unfairness is becoming an increasingly important political factor. For a range of reasons, young people appear to be getting a worse deal than previous generations, which may explain why voting patterns have divided so sharply by age. As the 2017 election showed, saying that older people should pay for social care gets a lot of applause from policy experts but is hideously unpopular with voters. Yet any proposal that essentially transfers the burden of paying for social care from older people to young people is likely to meet with some political opposition. (It is important to point out that both the Policy Exchange variant on nationalisation and the CPS proposal do include some element of contribution which should help to mitigate this issue.)

Another area of potential tension is the nature of the individual contribution under any form of co-payment (ie both Dilnot and Policy Exchange). If costs are calculated annually rather than cumulatively, it may punish someone whose care needs cost just under the cap, year on year, compared to someone who has more expensive needs but for a shorter period.

One advantage to the capped cost model is that it is already on the statute book, via the 2014 Care Act. This makes it far easier to introduce into the system in theory, though there may well have to be amending legislation or regulations.[53]

However, a major political downside to the Dilnot cap model is that it introduces significant regional distortions. Whatever the level of the cap, and whether it is inclusive of all costs or just care costs, it will benefit people differently depending on where they are located and how much wealth they own. For example, looking at average net household wealth among over-65s broken down by region, and the average cost of care,[54] it is clear that, on average, people in the North of

53 *Ibid.*

54 Using data on household wealth, broken down by age groups and region, from the Office for National Statistics, 'Net Total Wealth by Age Band of Household Reference Person and Region, Great Britain, July 2014 to June 2016', https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/incomeandwealth/adhocs/008867nettotalwealthbyagebandofhouseholdreferencepersonandregiongreatbritainjuly2014tojune2016, and modelling on the cost of care under a cap system by region by Independent Age and the Institute and Faculty of Actuaries, 'Will the Cap Fit?' (Independent Age and Institute and Faculty of Actuaries, 2017), https://www.actuaries.org.uk/system/files/field/document/WIll-the-cap-fit.pdf#page=21. The latter was divided by the former to work out what the average percentage of the wealth of a household aged over 65 would be depleted by having to pay for care until the cap was reached and the state stepped in.

England and the West Midlands will see a significantly higher share of their assets depleted due to care costs than people who live in London, the South of England and the East Midlands.

This makes the Dilnot proposal doubly unattractive politically. Not only would it be unpopular with those who have to cover the lion's share of their own care costs, but it would discriminate in favour of areas with high house prices and against newly Conservative voters in the so-called 'Blue Wall' seats.

It is worth going into this issue in more depth. Figures Tables 3 to 5, based on Office for National Statistics figures, show London, the South of England and the East Midlands have much higher levels of household wealth than the rest of England.[55] For example, while the median figure for over-65s in the South-East is £559,700, the figure for the West Midlands is £331,800 and the figure for the poorest region – the North-East – is just £255,500. While care costs tend to be slightly higher in the South and London, the gap in wealth is too large for this to outweigh this. A cap – at whatever level – benefits the South and London more.

Table 3: Median net household wealth, with a £72,000 cap

		With a £72,000 cap			
Region	**Median net household wealth**	**Three-year care cost**	**% assets depleted**	**Six-year care cost**	**% assets depleted**
North-East	£255,500	£82,306	32%	154,429	60%
North-West	£323,400	£100,469	31%	£209,934	65%
Yorkshire and Humber	£320,000	£96,788	30%	172,121	54%
East Midlands	£410,200	£92,100	22%	192,446	47%
West Midlands	£331,800	£110,199	33%	230,266	69%
East of England	£460,100	£136,057	30%	284,298	62%
London	£571,200	£129,122	23%	216,720	38%
South-East	£559,700	£144,421	26%	£288,132	51%
South-West	£450,900	£125,875	28%	£263,021	58%

55 *Ibid.*

Table 4: Median net household wealth, with a £35,000 cap

		With a £35,000 cap			
Region	**Median net household wealth**	**Three-year cost**	**% assets depleted**	**Six-year cost**	**% assets depleted**
North-East	£255,500	£82,306.00	32%	£130,499.00	51%
North-West	£323,400	£100,469.00	31%	£166,641.00	52%
Yorkshire and Humber	£320,000	£96,788.00	30%	£157,781.00	49%
East Midlands	£410,200	£92,100.00	22%	£139,493.00	34%
West Midlands	£331,800	£110,199.00	33%	£171,029.00	52%
East of England	£460,100	£136,057.00	30%	£178,724.00	39%
London	£571,200	£114,333.00	20%	£142,986.00	25%
South-East	£559,700	£140,819.00	25%	£175,192.00	31%
South-West	£450,900	£125,875.00	28%	£169,014.00	37%

Table 5: Median net household wealth, with a £100,000 all-inclusive cap

		With a £100,000 all-inclusive cap			
Region	**Median household net wealth**	**Three-year cost**	**% assets depleted**	**Six-year cost**	**% assets depleted**
North-East	£255,500	£82,306.00	32%	£106,591.00	42%
North-West	£323,400	£100,469.00	31%	£106,069.00	33%
Yorkshire & Humber	£320,000	£96,788.00	30%	£106,175.00	33%
East Midlands	£410,200	£92,100.00	22%	£106,310.00	26%
West Midlands	£331,800	£104,849.00	32%	£104,849.00	32%
East of England	£460,100	£104,606.00	23%	£104,606.00	23%
London	£571,200	£104,671.00	18%	£104,671.00	18%
South-East	£559,700	£104,528.00	19%	£104,528.00	19%
South-West	£450,900	£104,702.00	23%	£104,702.00	23%

It is of course worth stressing that it is highly unusual for people to spend six years in a care home: on average, residents only stay for 30 months.[56] We include the six-year scenario as it is that small number of people who have extensive and prolonged care needs who have been the focus of so much of the debate – and to illustrate that the longer the stay in care, the greater the geographical unfairness grows.

> **"Changing Dilnot to make it more politically attractive essentially means you end up with a system that is much more expensive, reducing the main benefit."**

One way to get around this is to try to create a regional cap. So for example you could have a different level in London versus the South-East versus the East Midlands. But this then creates a new set of political issues. For example, what about those who live near each other but fall into different administrative boundaries, even though their homes are the same value? In addition, the rate will be too low for some areas or too high for others (e.g. a South-East cap would either be too tight or too generous for a desirable part of the South-East versus a deprived coastal town). How should the regional level be set?

As is the case with other reforms, any attempt to try to make the system more generous does help with the political cost, but it is likely to be more expensive (since to help with the politics the cap would be higher in more costly areas).

One solution to fix this would be to adopt the Dilnot reform but have a high cap and a high floor – that is, the Government would ask you to contribute more of your own money to fund your care (if you could afford to), but protect more of your assets in return. For example, the costs cap might be set at £100,000 and the floor on asset values might be set at £250,000 – this would mean Government would start paying a person's care costs once they had spent £100,000 or their total assets had fallen to £250,000.

For most people outside of London and the south of England, this system would protect them, as their total assets would not be that much higher than the asset floor of £250,000. But the trade-off would be a more expensive system – potentially much more expensive. It would also mean that people in affluent areas were more likely to have to sell their homes, in a reverse of the original injustice. And even under this more generous system, there would still be people who would end up losing their home – unless the floor was set so high as to be meaningless. Changing Dilnot to make it more politically attractive essentially means you end up with a system that is much more expensive, reducing the main benefit.

The political attractiveness of each of these options will also be influenced by its cost. On the face of it, nationalisation (or at least state funding) would be the most appealing option, because it matches what many voters think already happens, protects their homes, and disguises the extra spending by including it in general taxation. (It also, incidentally, represents a subsidy from the poor to the rich relative to the current system, because those who are already paying their care costs will find them covered.)

56 Independent Age, 'Cost of average length of stay in a residential care home is equivalent to 26 years' worth of family holidays' (Independent Age, 2017). https://www.independentage.org/news-media/press-releases/cost-of-average-length-of-stay-a-residential-care-home-equivalent-to-26

Yet just because costs are disguised does not mean they do not exist. Each pound the state spends on social care means either higher taxes, higher borrowing or lower spending. That said, given the highly emotive nature of the social care debate, in particular over the issue of selling the family home, there is no getting away from the fact that spending more on this area is more politically attractive than other options. The goal should be to find the optimal point where the cost of reform in terms of higher taxes matches the benefits in terms of popular support.

A final political issue is that in a nationalised funding system, in which the state covers costs, it is much harder to justify discrepancies between care homes on an individual or regional basis. People who do not get a place in the care home they want, or feel that they (or their relatives) are not getting the quality of treatment that others receive, will be justifiably irate – just as they are when they cannot get their children into their preferred school.

Thus state funding in the medium term creates a political rod for the Government's back. It also creates the risk that in the next few years, private providers might withdraw from the sector if they fear that the Government will start to erode the value of any payments – particularly in the absence of self-funding residents or higher income via top up payments. At present, different care levels exist – which nationalised funding might be seen as paving the way to abolish.

The verdict

No solution will be universally popular – all have aspects that will elicit opposition. While a Dilnot-style cap system might be easier to introduce and considerably cheaper, it would fail the key political test of ensuring that no one has to sell their home. A nationalised funding system or a 'pension-style' would both ensure that no one ends up selling their home: the former is more superficially attractive, but involves more significant tax rises. Politicians will also struggle to justify different levels of care (as currently exist). The latter would assume the public can be convinced that social care should resemble the state pension rather than the NHS, though the National Care Entitlement has the similar feature of being clearly free at the point of use and available to all.

Table 6: The three models compared – political feasibility

	Political feasibility
Cap and insurance	
Pension	
State funding	

3. The Models Compared – Increasing Supply

One of the oddities of the debate around social care is that it tends to focus overwhelmingly on immediate funding needs.

Yet the crucial thing about any reform is that it puts the sector on a sustainable footing in the longer term – and in particular, that it improves the quality and efficiency of care available, particularly given the increases in demand and need that will be coming through the system over the coming years.

As discussed earlier, the number of people aged over 65 who struggle with activities of daily living is forecast to increase by 65% between 2015 and 2035.[57] There is already a large pool of unmet demand for care, with Age UK estimating that there are now about one and a half million people aged over 65 with unmet care and support needs, and this has grown sharply in recent years.[58] There has been a persistently growing gap between the supply and demand as far back as at least 2005/6.[59] Any reform of the system that makes social care more affordable is almost certain to lead to an increase in demand on top of this.

To cope with this it is imperative that the supply of care – domiciliary and residential – is improved and that it becomes more productive, getting better results for every pound spent and giving people the support they need.

"As discussed earlier, the number of people aged over 65 who struggle with activities of daily living is forecast to increase by 65% between 2015 and 2035."

Yet currently the system is going in the wrong direction. As Damian Green's CPS paper set out, productivity in the sector has fallen markedly in recent decades, falling by 1.7% on average every year since 1997.[60] There are widespread worries about the quantity and quality of staff, in both the domiciliary and residential sectors. Britain's stock of retirement housing is woefully small, while care homes are increasingly cramped and dilapidated. The sector is therefore going to need significant investment in the years to come.

The same is true in terms of staffing, modelling commissioned by the Department of Health and Social Care found that to keep up with rising demand,

57 Wittenberg, Raphael and Hu, Bo, 'Projections of Demand for and Costs of Social Care for Older People and Younger Adults in England, 2015 to 2035' (Personal Social Services Research Unit, 2015). https://www.pssru.ac.uk/pub/DP2900.pdf#page=7.

58 Age UK, 'Estimating Need in Older People' (Age UK, 2019). https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/active-communities/id204303-estimating-needs-report.pdf.

59 Dilnot Commission, 'Fairer Care Funding: The Report of the Commission on Funding of Care and Support' (Dilnot Commission, 2011). https://webarchive.nationalarchives.gov.uk/20130221121529/https://www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf#page=15.

60 'Health and Adult Social Care Services: Extracts from the July 2017 Fiscal Risks Report'. https://obr.uk/docs/dlm_uploads/Healthandsocialcare.pdf#page=17.

the number of full-time equivalent staff members would need to increase by on average 2.6% a year until 2035. However, since 2013, job growth in the sector has only managed 2% or lower per year.[61]

> **"Local authorities are the ones burdened with the cost of social care, which incentivises them to reject investment in care facilities or retirement housing because it might increase this burden."**

These problems are compounded by the high turnover and vacancy rates in the sector, which interfere with the quality of services and increase training and recruitment costs.[62]

Therefore, unless we want care to be rationed to an ever-greater extent, with waiting lists and stricter eligibility criteria, reforming the system is only going to work if it manages to increase the supply of care. That means more investment in the sector to build newer care home facilities and to hire more staff. It means better domiciliary care and a stable career path for those involved.

Existing investment has also come to be concentrated in areas where there are lots of self-funders. This is because local authorities have been paying sub-cost fees for care home beds. According to the CMA, self-funders now pay on average 41% more than local authority funded care home residents; in fact, in the 25% of care homes where most residents are local authority funded, the fees that local authorities pay are about 10% below the total cost of looking after residents.[63]

This means that where there are large numbers of self-funders, care homes can just about function and cover their operating and capital costs. But where the number of self-funders is small, care homes struggle to cover their costs.

Another major problem highlighted by the CPS and Damian Green paper is that current funding arrangements are structured in such a way to discourage local authorities from building new care homes or homes that are in general suitable for the elderly.

Local authorities are the ones burdened with the cost of social care, which incentivises them to reject any new local investment in care facilities that might increase this burden. This also applies to retirement housing, which is designed to give people the greatest opportunity to live independently for longer, requiring only domiciliary care, or even bungalows or other housing more likely to be desired by the elderly and more suited to their needs (e.g. due to lack of stairs). This is a tragedy since most older people want to live independently for longer, and it is more cost-effective for them to do so.

In private, many council leaders admit they are nervous about allowing more elderly residents into their area due to fears over future care costs. This means they are at best unsupportive and at worst actively hostile to building more care homes, retirement housing, bungalows and other facilities that would help reduce the cost of care and give older people better lives and more dignity. This is a tragedy and one that is eminently avoidable. To quote property specialists JLL: 'Only 0.6% of retirees live in Housing with Care, which is ten times less than in more mature

61 National Audit Office, 'Adult Social Care at a Glance' (National Audit Office, 2018). https://www.nao.org.uk/wp-content/uploads/2018/07/Adult-social-care-at-a-glance.pdf#page=31.

62 *Ibid.*

63 Competition & Markets Authority, 'Care Homes Market Study: Final Report' (Competition & Markets Authority, 2017). https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf.

retirement housing markets such as the USA and Australia, where over 5% of over 65s live in Housing with Care.'[64] Other countries allow for greater domiciliary care use within retirement housing settings – not a care home as such, but a group of homes where residents have day to day independence but if they fall ill or need temporary support that support is on hand. Another study by the HCA found that for a typical person aged 60 and above, moving to specialist retirement housing generates health and social care savings of £3,500 a year.[65]

In summary, the system needs to be reformed to change the structure of incentives so that new investment is encouraged rather than discouraged.

The good news is that all three models discussed in this report should lead to greater investment and therefore supply, at least in the medium to long term. This is because they all provide, to differing degrees, the certainty of future cash flows that operators and investors in the sector need.

However, it is likely that some kinds of reform will improve the situation more than others.

Given this, a key advantage of the CPS proposal is that while councils are still involved in the provision of care, the funding is on a national basis. This would return to the structure seen in the 1980s, during which care bed provision grew by 84%.[66] Private and local authority providers were able to expand in the confidence that the money would follow the resident – with the same being true, of course, of providers of domiciliary care. However, the 'community care' reforms, based on the Griffiths review of 1988, saw councils given control of the system.[67] Expansion of care beds promptly ground to a halt, with capacity expanding by just 13% in the 1990s.

Table 7: UK social care bed provision[68]

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)	404,163	NA

A key attraction of a Dilnot-style reform is that it promises to increase investment via the development of a much larger private insurance market for social care and new financial instruments pertaining to social care costs. Private capital will therefore pay for the necessary investment in and expansion of the sector.

However, there is a major question mark over how likely this is to develop. To quote The King's Fund: 'The extent to which the financial services industry, particularly insurers, will respond depends on a stable policy environment, which in turn requires a broad consensus across the political parties that will endure beyond a single parliament and across several

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

65 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

66 Green, Damian, 'Fixing the Care Crisis' (Centre for Policy Studies, 2019), p30. https://www.cps.org.uk/files/reports/original/190426143506-DamianGreenSocialCareFinal.pdf.

67 Wanless, Derek, 'Securing Good Care for Older People: Taking A Long-Term View' (King's Fund, 2006), P13. https://www.kingsfund.org.uk/sites/default/files/field/field__publication__file/securing-good-care-for-older-people-wanless-2006.pdf

68 Green, Damian, 'Fixing the Care Crisis' (Centre for Policy Studies, 2019), p30. https://www.cps.org.uk/files/reports/original/190426143506-DamianGreenSocialCareFinal.pdf.

generations.'[69] Moreover, as discussed above, the international evidence does not support the idea of a large-scale private insurance market emerging for full social care costs.

More likely to create a functioning market, we would argue, is a more mixed reform along the lines of the CPS proposal – under which a complementary insurance system will emerge through which people can top up the free basic care that the state will pay for. As already outlined, a number of countries do have well developed private insurance markets for complementary social care. However, such a market would still take time to develop, and until it did the Government might have to inject large sums into the system to support it, as our earlier paper readily admits.[70] Dilnot is therefore a riskier solution as it relies on a model yet to evolve in any other country.

More state-heavy solutions, which strip out private investment and leave funding responsibility in the hands of government, would also rely on the state funding future investment. This would involve social care having to compete for capital with all the Government's other priorities, and inevitably becoming starved of investment. The likelihood is that, as now, the system would survive on emergency short-term injections of funds from central government when it reached breaking point. This is not a good recipe for the certainty that the sector needs in order to invest and commit to permanently larger supply.

This problem is likely to be even more acute if, as some have suggested, social care is not just nationalised in terms of funding but fully absorbed by government, either as part of the NHS or as a separate 'National Care Service', as Labour called it in 2019.[71]

While this might be a popular move, given how popular the NHS itself is, and might give the Government greater control over how the system works, it would very likely do little to increase supply. In fact, because it would take time to carry out the policy, investment would likely fall – as the announcement of nationalisation would scare off investors and firms from injecting extra resources into the system.

"As already outlined, a number of countries do have well developed private insurance markets for complementary social care."

In the longer term, as with the 'pension-style', the state funding approach does go a long way towards removing the disincentive local authorities currently have to approve new social care facilities or retirement housing – since they will no longer have to bear the burden of paying for the social care of any new residents.

Such new facilities are crucial not only for expanding supply and improving productivity, but also for improving quality, since, as previously noted, much of the existing social care stock is old.[72] In fact, reform along the lines of either the pension or state funding models could encourage a

69 The King's Fund, 'Briefing: The Dilnot Commission Report on Social Care: 13 July 2011' (The King's Fund, 2011). https://www.kingsfund.org.uk/sites/default/files/field/field__publication__file/briefing-dilnot-commission-social-care-jul11.pdf.

70 Green, Damian, 'Fixing the Care Crisis' (Centre for Policy Studies, 2019). https://www.cps.org.uk/research/fixing-the-care-crisis.

71 Labour, 'Labour announces plan to head off social care crisis' (Labour, December 8, 2019). https://labour.org.uk/press/labour-announces-plan-to-head-off-social-care-crisis/.

72 Hinrichs, Eilert and Sparey, Jonathan, 'U.K. care homes: is the market finally on the brink of a new wave of investment?', L.E.K. Insights, vol xxx, no 41. https://www.lek.com/insights/ei/uk-care-homes-market-brink-new-wave-investment.

lot of new social care development – since it could become politically advantageous to approve new care facilities, retirement housing, etc. It is possible we might even see local councils competing to attract new social care investment once they no longer bore the burden of funding any extra costs that resulted from older people moving into their area.

In comparison, the Dilnot proposal would see local authorities continuing to bear primary responsibility for funding social care. The Dilnot Commission's report does call for central government to properly fund them to do so,[73] but given the pressure that government budgets are bound to be under, it is unclear that long-term funding of the requisite size would be forthcoming. To be fair, all the proposals discussed in this report rely on additional central government injections into the system on top of the cost of their main reforms. All the variants of reform would therefore be at risk if they could not secure this funding.

However, and more importantly, the Dilnot model keeps the structure of the current system, with local authorities in charge of funding and provision, which as noted is a damaging system that underprovides care homes, retirement housing, supported housing and even just homes more suitable for older people.

The verdict

Whichever reform scheme is chosen, it should help to improve the long-term viability of the sector and encourage an increase in supply, by providing more certainty and dealing with the tail risk. The 'pension-style' has the best chance of increasing investment and supply – provided a private insurance market for complementary social care develops. But all models of reform will require additional government funding in the short term in order to shore up the system.

Table 8: The three models compared – increasing supply

	Increasing supply
Cap and insurance	🔴
Pension	🟢
State funding	🟡

73 Dilnot Commission, 'Fairer Care Funding: The Report of the Commission on Funding of Care and Support' (Dilnot Commission, 2011). https://webarchive.nationalarchives.gov.uk/20130221121529/https://www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf#page=9.

Conclusion

It is now urgent that we reform the social care system.

The coronavirus crisis has underlined how precarious the current funding situation is. We cannot continue to go on talking about reforming the system but never getting round to actually doing it. Simply bailing the system out every time it appears critically endangered is no longer feasible. We need fundamental long-term reform so that the sector has the certainty to invest in the extra capacity and better-quality care that all our families are going to require.

Assessing the three models discussed in this report, we would argue that the hybrid model suggested by the CPS – a national basis of provision, with private provision on top – is the most likely to succeed, judged against the three key metrics we have identified. But like all the other models on offer, it has disadvantages too. No model is perfect.

“We need fundamental long-term reform so that the sector has the certainty to invest in the extra capacity and better-quality care that all our families are going to require.”

The Government is not going to be picking the best from a range of wonderful options. It is going to have to choose which trade-offs to make, and then convince the voters that it has made the right choice. But the pandemic has ensured that ministers cannot put off grasping the nettle any longer. The upcoming Spending Review is the moment to deliver a new settlement that finally puts care for the elderly on a stable footing for the long term.