The Future Funding of Care and Support

National Pensioners Convention
submission to the
Commission on Funding
of Care and Support

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Summary
The existing care system suffers from a number of inherent problems; namely its complexity, the unfairness of means-testing, a postcode lottery of funding and standards, and its lack of personalised services. In addition there are concerns surrounding the standards and quality of care services, the training, remuneration and employment conditions of the care workforce and the lack of a robust and effective regulation and monitoring of care providers.

The system is therefore in urgent need of reform, and any attempt to respond to the Commission's pre-set questions in a single sentence or paragraph could be abstract and meaningless. However, we use this summary to set out as concisely as possible the content of our submission, using the Commission's questions as headings:

Question 1: Do you agree with the Commission's description of the main opportunities and challenges facing the future of funding of care and support?

- It is impossible for the Commission to narrowly look at the issue of funding without also considering what it is they are seeking to fund. Much needs improving within the current system, and that will inevitably demand greater levels of financial support. It is therefore imperative that the Commission also address issues such as quality, standards and availability of services.
- The personalisation of care must not be regarded simply as the introduction of individual budgets. Individual budgets raise serious concerns about the safety and protection of vulnerable individuals, as well as the emergence of third party organizations who will offer to manage budgets at the expense of care funding.

Question 2: Do you agree with the Commission's description of the strengths of the current funding system, and its potential shortcomings? Do you think there are any gaps?

- The existing care system and its funding suffers from a number of inherent problems; namely its complexity, the unfairness of means-testing, a postcode lottery of funding and standards, and its lack of personalised services. Also there needs to be greater recognition of the role and value that family/informal carers provide, including payment of the carer's allowance to individuals over pension age.
- The widespread privatisation of the care sector over the last decade has been responsible for reducing the standards and quality of care received by older people in the community. For these are commercial organisations that happen to operate in the care "industry" and their main concern is profit. Thus so-called "best value" usually means "the cheapest" and this often leads to higher costs in the long run since there is a lack of a robust and effective regulation and monitoring of care providers and of the link between the payment of staff and the quality of care provided. Thus those with low or moderate care needs can quickly move into substantial and critical care needs at higher cost.

Question 3: Given the problem we have articulated what are your suggestions for how the funding system should be reformed? How would these suggestions perform against our criteria that any system should be sustainable and resilient, fair, offer value for money, be easy to use and understand and offer choice? Please also take into account the impact that your suggestions will have on different groups.

- The Commission has made it clear that it wants to find a funding solution that balances the responsibility between the individual and the state. At present, the current balance is already tipped too far on the side of the individual and the fairest and most equitable way of providing a universal, free-at-the-point-of-need National Care Service would be through general taxation. All employed people already pay tax and National Insurance contributions; this is a cost efficient way to pay and most would welcome the assurance of a National Care Service for themselves and their elderly relatives paid for throughout their working life.

1. Introduction

On 20 July 2010, the Secretary of State for Health, Andrew Lansley, announced the creation of the Commission on the Funding of Care and Support, alongside its terms of reference.

From the outset it has been clear that the Commission would be advised by two panels of experts – one from academia and the other from the financial sector. However, it is worrying that social care professionals have not been given the same level of access to the Commission as the insurance industry. Furthermore, despite two requests, Britain's biggest organisation of older people, the National Pensioners Convention, was not invited to be part of the chair's group of external stakeholders.

The Commission's independence is also rather curtailed by the fact that the criteria against which it will judge various funding models has already been agreed by the Secretary of State for Health, and is in line with the government's decision to reduce overall public spending.

In addition, it is almost impossible to look at the issue of funding, without also considering what it is you are seeking to fund. For example, the existing care system is riddled with complexity, an unfair system of means-testing to determine payment, a postcode lottery of funding and standards; provides little support for family carers and has a distinct lack of personalised services.

There are longstanding concerns surrounding the standards and quality of care services, the training, remuneration and employment conditions of the care workforce and the lack of a robust and effective regulation and monitoring of care providers.

To build a care system that can address all these issues will therefore cost more than one which simply seeks to continue with the status quo. Given such major concerns, it is therefore imperative that the Commission also address issues such as quality, standards and availability of services.

In considering the central issue of funding, the Care Commission should also be aware of the mistakes made by the previous administration. The last government made a serious mis-calculation when in just one paragraph in its green paper it dismissed tax-funded care without any serious analysis or consideration. This mistake was made even more obvious when the public consultation meetings around the country were coming out very strongly in favour of such an option. The Commission must therefore ensure that the idea of a tax-funded, free at the point of delivery, universal national care service is properly debated and assessed.

2. The challenges we face

There is much about the existing social care system that gives serious cause for concern, particularly when considering that it has responsibility for looking after some of our most vulnerable older people.

It is estimated that around 1m pensioners receive some form of care in their own home, with a further 500,000 occupying places in residential care.

All domiciliary care in the home is means-tested, and only those individuals with an annual income of less than £13,000 receive their services free. For those with income above this level, the means-tested charges vary widely depending on each local authority area.

Those individuals needing residential care, with assets (including the value of their property) of more than £23,250, also have to fund the entire cost, whilst those with between £13,000 and £23,250 are means-tested and pay a proportion. Only those with less than £13,000 will have all their charges paid by their local authority.

One of the biggest problems in the care system remains the artificial distinction between nursing care which is provided free at the point of delivery by the NHS, and personal or social care which is means-tested in the community. Today frail elderly people are moved as quickly as possible from hospital into nursing homes, or they spend a long and stressful period at the end of their lives, paying a high cost for care in their own homes. Not only has the division between nursing and personal care made the possibility of providing good quality, seamless support more difficult to achieve; it has also been responsible for incorrectly labelling illnesses such as dementia as social care and pushed services beyond the boundaries of the health service.

The existing care system has also created a huge care gap between need and availability of services. In 2003, the Fair Access to Care Services (FACS) guidelines were introduced as a response to the outcry against the “postcode lottery” which allowed local authorities to use different criteria for assessing the need for care. The guidelines state that every local authority in England must use four standard criteria: critical, substantial, moderate and low to assess and deliver social care, but all the evidence shows that most councils now only help people with substantial or critical needs, leaving many needing help to fend for themselves or rely on friends and family for support.

It is estimated that at least 160,000 households are currently denied the help they need, whilst rising charges for those still receiving care in their own homes, are forcing older people to reduce or even stop their support services.

A National Coalition on Charging report[1] in 2008 revealed that:

- 80% of people surveyed who no longer use care services say charges contributed to their decision to stop their support
- 29% of respondents did not feel their essential expenditure (related to impairment/health condition) was taken into account in financial assessments to pay charges, meaning they have to choose between essential support and equally essential food, heating or utility bills
- nearly three quarters (72%) of people surveyed believe the government should think about the charges people pay for support at home in any plans to reform adult social care
- a fifth (22%) of people surveyed who currently use support suggested they would stop if charges increased further

Other evidence shows that over a three year period up to 2006, the number of older people using services dropped from 867,000 to 840,000 – at a time when the population aged 75 and over increased by nearly 3%. Likewise, between 1997 and 2006 the number of households receiving supported home care fell from 479,000 to 358,000.[2]

As a result of such rationing, those with low and moderate needs have no choice but to either rely on voluntary organisations or family members to help, or do without. Naturally, this situation can lead to a worsening of their condition and their needs may eventually reach a substantial or critical level. The cost of providing this extreme level of care is therefore more expensive in the long term than would have been the case with earlier intervention; when needs are at a lower level. Any solution must therefore be for the long-term.

However, what is extremely worrying is that because the social care system has long been the Cinderella service of the welfare state, it has encouraged low expectations from those who it is supposed to support. Many individuals have modest desires about what help they might get when entering the system. Many feel they are receiving less support than they need – or are trying to muddle through without any help or guidance.

The exclusion of lower bands of eligibility means that people have particular difficulty in getting support with practical – yet vitally important tasks – such as housework, gardening and shopping. The National Pensioners Convention's own research has found the care gap can include a lack of help with cooking, gardening, housework, visiting day centres, going out, shopping, DIY/maintenance, adaptations to property (ramps, showers etc) and bathing.[3]

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[1] Charging into Poverty, National Centre for Independent Living, 2008
[2] The State of Social Care 2006-7, Commission for Social Care Inspection, 2007
[3] Survey of social care users and providers, NPC, 2007

Ultimately, the burden created by this care gap is felt by the individual's family and carers. Despite a commitment from the previous government to 'valuing' carers through a Carers' Strategy which is due to come into force by 2018, there is no suggestion from the Coalition of changing the current rules on the carer's allowance which prevents someone in receipt of a state pension from claiming. Many support services, such as respite care, are also unavailable to existing carers. As a result, the constant pressure of looking after a highly dependent individual, without the necessary support and help can lead to passive neglect, because the older carer is simply no longer able to cope.

3. The personalisation of care

The personalisation of care is at the heart of the government's proposals for reform. Early intervention, prevention, re-enablement, advice and guidance and more control for service users are all positive developments in the care service – but the idea of personalisation must not be confused with the introduction of personal or individual budgets.

Local authorities are already facing an impossible task of delivering personalised care and support against a growing demand, with no extra funding, whilst at the same time trying to generate efficiency savings. Government policy and local authority practice, together with tightening budgets, therefore mean that the personalisation agenda is helping to produce a market-led model of care provision.

Local authorities increasingly outsource services to private and third sector providers; while under the direct payments scheme, an assessment is made of the user's needs in terms of hours, and is converted into an amount required to deliver that care in the form of a personal budget which users can spend as they choose.

However, the introduction of individual budgets raises a number of serious concerns. Many budget holders will be met with a bewildering choice of care providers, consisting of local authority services, private companies and the voluntary sector. The individual will therefore need to be directed to the "experts" offering advice and services and will inevitably be drawn into the growing market where private companies, the voluntary sector and charities compete for contracts to supply such services.

Research also shows the negative physical and psychological effects that the responsibility of managing individual budgets can have on older people. The IBSEN Individual Budget Pilots Evaluation report October 2008 showed that service outcomes for those using an individual budget in the pilot were not improved for older people, and that their psychological well-being was damaged.

However, despite this obvious drawback for older people, government seems intent on promoting individual budgets as the only mechanism through which care services can be accessed. This 'cash for care' model has shown that some local authorities are now refusing to offer a choice of how services can

be accessed – with access to care being limited through direct payments only. The principle that all service users should have an individual budget in order to receive a minimal service is therefore inappropriate, especially as most frail older people simply want a decent service arranged for them that meets their needs. Furthermore, under a national care system with proper assessment and funding, individual budgets would of course be completely unnecessary for delivering personalised care.

Ultimately, the introduction of individual budgets will transfer risk and responsibility either to the individual who needs social care or to their relative(s). They must now take on management tasks or deal directly with the private companies which will provide their advice or care for profit. However, there is no clear guidance for the individual when becoming an employer.

Fundamentally, expecting some of our most vulnerable older people to take on the responsibility of micro-employers – recruiting, dealing with payroll matters, contracts, discipline, employment rights, paying tax and national insurance – is simply unrealistic. In effect, rather than giving choice, individual budgets open up opportunities for abuse by those who manage the individual's affairs and those organisations who see it as a chance to win contracts and make profits. Already evidence is emerging around the country that private agencies are offering to manage budgets for an average cost of 10%-15%; which in most cases will be paid out of the money that should have been used on care. It should also be noted that at the moment, these brokers currently fall outside any regulatory framework.

In addition, individual budgets raise serious concerns about the safety and protection of vulnerable individuals who will be responsible for employing their own care workers, who as lone workers are at present also exempt from registration, regulation and inspection. The responsibility of individual budget holders for arranging suitable cover for staff absence due to sickness and maternity leave also adds to this concern.

Far from enabling a highly-skilled and motivated workforce, the model of provision that is actually emerging encourages low pay and poor conditions, and risks entrenching problems of inadequate recruitment, retention and career development.

Furthermore, shifting funding and responsibilities onto individuals undermines local authorities, local democracy and the role of the welfare state. The personalisation of care is therefore becoming synonymous with reducing choice, increasing privatisation and allowing the growth of an unregulated care service.

4. The role of carers

There is a need to recognise the important and different role played by 'family/informal carers' against that of employed care workers. Supporting carers is an important part of personalising care and support. Women are the majority of paid and unpaid carers across the UK; generally underpaid and undervalued for providing an increasingly skilled demanding service.

Inadequate funding of care means that women sacrifice their own employment prospects by providing a free service to taxpayers.

However, many support services are not available to existing carers, and this places a sometimes intolerable burden on many individuals; a large number of whom are also of pension age. Essential to supporting this army of unpaid carers is the need for greater recognition of their role and the value they provide. This should include paying the carer's allowance to older people in addition to their state pension and giving carers the right to have their needs assessed by their local authority and receive any appropriate services and support.

5. The care workforce

In assessing the funding of care, the Commission should also consider the role of the workforce. This accounts for 80% of the total expenditure in social care, but inevitably affects 100% of how individuals experience the service. Achieving a high quality care service is therefore intrinsically linked to the nature of the staff it employs. However, the dominance of the private sector in care provision makes this aspiration virtually impossible to achieve.

In March 2009 the CSCI/CQC registered providers list showed that the private sector now operates 75% of domiciliary care agencies. For residential care the figure is approximately 69%. Any attempts at changing the nature of the care sector therefore means addressing the role of the private companies that operate within it.

TV programmes such as Panorama, and evidence from trade unions operating in the care sector, have shown that the privatisation of much of social care across the UK has led to poorer pay and conditions, a high turnover of staff and limited access to training or career development. Consequently, this has meant that private care providers have not delivered on the high standards of quality of care that were originally promised.

Too often local authorities have awarded contracts for care to the lowest bidder. This race to the bottom has driven down, not only the terms and conditions of the workforce, many of whom are on the national minimum wage, but also the level, quality and standard of care delivered to the user. Care assistants and home carers are recognized by the Low Pay Commission as among the lowest paid workers in the UK, with median pay rates for care workers employed by private agencies currently standing at just £6.30 an hour[4]. In practice even this figure can be lower when care workers are paid by the visit, rather than the hour.

A snapshot of qualifications in the domiciliary care sector for 2007 also showed that nearly three quarters of all staff were without any suitable qualification.[5] Evidence suggests that the same trend is also apparent in the residential care sector as well. Out of 32,000 domiciliary staff employed; just

[4] Skills for Care, NMDS-SC, Dec 2008-Feb 2009
[5] Skills for Care, NMDS-SC, November 2007

0.9% had a Level 4 or higher qualification, 3.9% had achieved Level 3, 18.1% Level 2 NVQ, 0.1% Level 1, 5.7% had other relevant qualifications and 70.7% possessed no qualification at all.

Often newly appointed care workers receive little more than instruction via a short film or ‘on the job’ training – usually from equally inexperienced and unqualified colleagues.

Yet these individuals are in the front line of caring for some of our most vulnerable older people; undertaking some of the most challenging work, in a highly pressurised environment. They need to be able to detect the signs of dementia, and other illnesses, as well as having skills in personal care, first aid, health and safety, manual handling, food hygiene, communication and how to properly relate to those with mental and physical disabilities. However, very few even come close to this requirement.

Furthermore, care workers often operate to tight schedules that do not allow the time necessary to support clients in self-care, or to establish the relationship that is the necessary foundation of a high quality personalised service and a key factor in job satisfaction. Travelling time between clients is also unpaid, which adds to the growing pressure on staff to reduce the time they spend with the client, despite being contracted for a visit of a minimum duration.

Many care workers are therefore forced into a position of being “shock absorbers” for the tensions within the system. While the quality of care is undermined in some cases, in others it is the commitment and kindness of the workers themselves that compensate for the system’s deficiencies at the expense of pushing them to do more and work longer than their contracted hours.

That is why there needs to be greater recognition that caring for vulnerable older people with diverse mental and physical needs is both a skilled occupation and one that carries a high level of responsibility. The sector struggles with problems of recruitment and retention, and the shift to local authorities contracting out service provision means that employment is now predominantly with private sector agencies. Precarious employment relationships, such as pseudo self-employment and zero hours contracts, are already common. The casualisation of employment is also likely to increase as the use of individual budgets and direct payments becomes more widespread.

In particular, we must develop a stable, well-trained, qualified and properly remunerated workforce with capacity and time to respond to an individual’s needs. In doing so, we must also be prepared to accept that good quality care cannot be delivered by low paid, unqualified and overworked staff. As a result, this means adopting a new approach to care; one which raises the status of the profession and in doing so also raises standards by addressing the inherent contradiction between the delivery of high quality care and the role of the private sector.

6. Monitoring and regulation

In recent years there has been a systematic weakening of the rules and regulations surrounding the provision of care services. Critics have argued that the Care Quality Commission (CQC) has uprated many care homes in an attempt to reduce the number of site inspections required, whilst at the same time downgrading the standards for regulating and inspecting domiciliary care in an individual's own home. Even the limited 'star-rating' system for care homes has now been suspended.

It is also estimated that 60-70% of home care in future will be provided by individuals (either directly employed by the user or self-employed) because they will be able to get more money than if they worked for an agency or contractor. However, they will not be regulated by the CQC and there will be no requirement for any training or qualifications, a criminal CRB check or automatic registration under the Independent Safeguarding Authority's new vetting and barring scheme.

In the residential care sector, regulation is also extremely weak. At present within care homes, only one member of staff is required to have an appropriate care qualification, but even they do not have to be situated on-site.

A return to proper regulation and standards is therefore essential to any proposals for reform. New requirements for registration of care providers should be re-introduced (drawing on previous CSCI guidelines) for 50% of staff in care homes and all new staff working in domiciliary care to be suitably qualified. In addition, care staff employed either by an individual, local authority, agency or care home company should have an appropriate qualification as a minimum essential requirement for registration.

7. The future funding of care

The Commission has made it clear that it wants to find a funding solution that balances the responsibility between the individual and the state. Already we have a situation whereby care at home and in the community is means-tested, with only the very poorest receiving any services free.

In 2008, the average fees for care home residents across the UK were £34,528 per year for nursing care and £24,128 for residential care.[6] A typical stay of four years of care and accommodation in an average care home would therefore cost over £270,000. Over the last ten years the average cost of nursing care has also increased by almost 75%, whilst residential care has risen by 70%. If fees therefore increase at a rate of 5% per annum, in ten years the average nursing care figure of £34,528 will have reached £56,242. If the costs of accommodation and personal care were also included, that figure would be around twice as much again.

[6] Care of Elderly People UK Market Survey, Laing and Buisson, 2008

It is also calculated that around 39% (146,000) of all care home residents are paying their care fees privately, without any assistance from the state or local authority.[7] In addition, an estimated £5.9bn is also being spent by individuals on domiciliary social care through private contributions and charges.

In a NPC social care survey[8] in 2007, almost half of all users were paying up to £50 a week for home care; with up to 20% paying between £100 and £200. It would therefore appear that the current balance is already tipped too far on the side of the individual and needs addressing.

90% of respondents to the Caring Choices Report[9] in 2008 rejected the present means-tested system, preferring a stronger universal element determined by care need rather than income or wealth. Research also shows that free personal care based on need is the preferred option and the most popular amongst all age groups.[10]

Countries such as Austria, Germany, Japan and the Netherlands all provide social care according to universalist principles that avoid means-testing as a condition of access. The World Health Organisation has also noted: “Generous universal social protection systems are associated with better population health, including lower excess mortality among the old.”[11]

Of course, it is easy for politicians, guided by the need for short-term electoral advantage, to argue that taxation is unpopular with the general public. Yet our public services continue to enjoy popular support amongst all age groups. Furthermore, there is little evidence to show that today’s younger generations are unwilling to support the care of their aged parents, and themselves in future years, through the use of general taxation. Already residents and their families are topping up local authority fees to move into or remain in the care home of their choice.

In fact society as a whole already practices the principle that the risk and cost of providing education, health care and the defence of the nation should be spread across the population. Why then should this same principle not apply to the care of our most vulnerable older citizens?

This issue was central to the Royal Commission’s report into long-term care published in 1999. They concluded that: “Long-term care is a risk that is best covered by some kind of risk pooling – to rely on income or savings, as most people effectively have to do now, is not efficient or fair due to the nature of the risk and the size of the sums required.”[12] Furthermore, they went on to argue: “The most efficient way of pooling risk, giving the best value to the

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[7] Care of Elderly People UK Market Survey, Laing and Buisson, 2009
[8] Survey of Social Care Users and Providers, NPC, 2007
[9] The Future of Care Funding: time for a change, Caring Choices Consortium, 2008
[10] Expectations and aspirations: Public attitudes towards social care, Price Waterhouse Coopers, April 2009
[11] Closing the gap in a generation, WHO, 2008
[12] With Respect to Old Age, The Royal Commission on Long-Term Care, March 1999

nation as a whole, across all generations, is through services underwritten by general taxation, based on need rather than wealth."

It is our view that the state should therefore provide a high quality, comprehensive system of social care that meets national standards and is available to everyone, based on their care needs. Tax-funded care would offer the fairest and most equitable way of providing a universal, free at the point of need National Care Service which would end the health and social care divide.

8. Conclusion

The Care Commission clearly faces a huge challenge to find a long-term solution to a problem that has been consistently ignored, and with it, a huge expectation from both existing and future users of the service.

The challenge of an ageing population will clearly demand that society provides for their needs, even if it means reordering the priorities for public spending. There is no evidence that today's workers are not willing to pay sufficient taxes to fund the kind of system that they wish for their parents and themselves as they get older.

In addition, the role of in-house and public sector provision needs to be re-built and there should be a re-introduction of specialist geriatric wards into hospitals. Publicly provided care homes and care services, based on high levels of training and workforce development could play an essential role in setting and maintaining standards and quality across the sector.

Reordering public spending priorities and addressing the need for increased taxation, diverting money from private health care provision and introducing a windfall tax on their profits would provide sufficient resources for a 21st century social care system that meets national standards and is available to everyone, based on their care needs, rather than their income.

If there was any doubt as to why urgent reform was needed, a recent case study of life in a care home makes it clear.

Elisabeth Loe's late father, Albert Thompson, was diagnosed with vascular dementia in 2005. The former aircraft engineer wanted to stay in his own home and spent more than £160,000, his life savings, in four years on home care.

"Two carers were excellent, a lifeline for me, but all the others were terrible," Mrs. Loe said. "My father would be regularly left soiled, unshaven and with food around his face and clothes. Some of the carers used his condition as an excuse to do nothing, saying he wouldn't let them come near him, rather than coaxing and persuading him."

Some carers could not speak English, others took home food bought for her father and others slept on duty. Mrs. Loe added: "Someone from the agency

said to me: 'We are a commercial organisation that happens to operate in the care sector.' I think that says it all."[13]

In 1997, the British Geriatrics Society produced a series of expectations and recommendations for the care of older people. Their proposals stated that health and care services should aim to: "Enable older people to lead as full and independent a life as possible as active members of the community; provide comprehensive health and social service to support people in their own homes; ensure dignity is preserved and distress minimised at all times, ensure training and high professional standards are established and maintained by all staff."[14]

This is an ideal for which we must now strive.

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[13] 25 January 2011, The Times
[14] Standards of Medical Care for Older People, British Geriatrics Society, February 1997