



Fixing Social Care

New funding, new methods, new partnerships

By Eamonn Butler and Paul Saper

BRIEFING PAPER

EXECUTIVE SUMMARY

THE PROBLEMS

- Covid-19 has focused attention on the crisis in residential and nursing care homes for the elderly, although the crisis in adult social care is deep and has been growing for many years.
- Alongside care of the elderly, half of local government care spending goes on the needs of people under 65 with physical disabilities, mental health or learning problems. Because of rising longevity, the demand for care in each of these groups has grown 3-4% per annum over this century as parents can no longer look after children all their lives.
- The adult social care system is a lottery and widely perceived as unfair.
- Most care homes with local authority-funded residents are over 20 years old and no longer up to standard.
- Too many self-funders in care homes receive a raw deal from providers. While they no longer subsidise local authority-funded residents, they are insufficiently protected by the financial regulators. They have no control over future fee increases, and the margins on the 'hotel' element of their care that they are required to pay may be as high as 50% or more.
- Live-in carers typically have no qualifications, and many are paid less than the national living wage.
- Proposals such as raising public care budgets, raising the asset qualification, or making social care free to all will not work on their own. They do not change the fact that the care system itself is dysfunctional, full of perverse incentives, and badly undercapitalised.
- Meanwhile, families are unwilling to save for something that only one in three will need. And insurance is not viable while the 'long-tail' (risk that some individuals may need many years of expensive care) remains.
- To bring about effective change for the long term, policymakers must find solutions to the structural, incentive and supply problems in the system.

THE SOLUTIONS

If we want to address the deficiencies in long term care provision, avoid future crises and ensure equitable care for all, we need to accept the following realities and steps:

- Huge new investment in care homes is needed. This is unlikely to come from public budgets. Therefore, we propose a new mechanism to bring in long term investors, helping create better-quality, better-value partnerships in more up-to-date facilities.
- Future sustainability and pressures on public funding, now greatly exacerbated by the Covid-19 pandemic, require new ways of enabling those individuals and families who can make greater provision themselves to do so. This could involve insurance or personal care savings accounts and other options.
- To make insurance viable and affordable to the many, the state should pick up the ‘long-tail’ costs of those needing many years of care. Involving insurers would also put pressure on providers to restructure and deliver better value for money.
- Older people enjoy a number of dedicated benefits, some starting even before they reach pensionable age. Making public care budgets sustainable will mean older but wealthier people making more of a contribution to their own generation’s care costs.
- Public funding and long term care budgets should give much higher priority to younger adults with physical disabilities, mental health or learning problems, whose needs have long been under-resourced.
- Local authority-funded care at home focuses on price, not quality. It should instead embrace new providers who have developed better delivery technologies, integration with healthcare, and training and recruitment of carers.
- A more rational and affordable care system will involve disrupting the market, but will deliver better supply, sustainability and fairness in a more functional system. Without a radical overhaul of provision, increases in public funding will not avoid future crises.

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INTRODUCTION¹

The social care sector had been suffering considerable strain for decades, even before the Covid-19 crisis struck. UK local authorities' adult social care budgets were already under mounting pressure, which the Government sought to ease with funding boosts in the run-up to the December 2019 election. However, critics complained that this was a short-term and insufficient fix.²

Care home providers, meanwhile, were increasingly dismayed that the fees they received for local authority-funded residents scarcely (if at all) covered costs, and many were already abandoning the earlier arrangement by which self-pay residents subsidised local authority-paid ones, putting even greater strain on local authorities' budgets. Meanwhile, families who had to fund long term care themselves were finding it increasingly costly and hard to afford.

From 2017 onwards the Government promised a Green Paper, aiming to “ensure that the care and support system is sustainable in the long term” and to improve integration with health and other services and between different care providers.³ During the 2017 General Election campaign, former Prime Minister Theresa May said the proposals would include a lifetime “absolute limit” on what people pay for social care—though there was less agreement on how this would work, how much it would cost, and how it would be funded.⁴ After the 2019 election there was talk of a White Paper, before the Covid-19 outbreak cut discussions short.

The Covid-19 crisis highlighted the pressures on the care home sector. In particular, care homes are finding it more difficult to hire and retain staff,⁵ while occupancy rates, which are critical to the viability of care homes, have fallen. According to Knight Frank reports that survey more than 60,000 beds each week, occupancy has fallen from 87.4% at the end of February to 79.8% on 17 May, 2020, a fall of approximately 36,500, to 382,700 residents.⁶ People's current reluctance to be in an environment where disease can spread very quickly is reducing new placements into the homes and this will continue to be a problem particularly if the country were to suffer a second wave of COVID-19. However, the need for care will not go away. It simply means that many elderly or vulnerable people will remain at home, tended by part-time carers or by family members who are not well qualified or equipped to do so. Providers of care are also concerned that they have received a lower proportion than they expected of the emergency funding that government intended for care because of local authorities' loss of income and other pressures on their budgets.

¹ This paper updates a previous ASI publication, *Stable Footing: Ensuring a sustainable future for social care*, authored by Paul Saper and Eamonn Butler and released in June 2018.

² See, for example, <https://www.ageuk.org.uk/latest-press/articles/2019/november/in-england-74000-older-people-have-died-or-will-die-waiting-for-care-between-the-2017-and-2019-general-elections/>

³ <https://commonslibrary.parliament.uk/research-briefings/cbp-8000/>

⁴ <https://www.bbc.co.uk/news/election-2017-40001221>

⁵ <https://www.carehome.co.uk/news/article.cfm/id/1575544/Care-home-inspectors-identify-a-lack-of-staff-and-poor-manual-handling-skills>

⁶ Knight Frank, *Care Home Occupancy Report*, 29 May

Yet whatever the immediate issues, fundamental long term problems persist in the care sector. For example, many care homes are obsolete and need to be replaced, while care at home needs complete redesign using modern technologies. Such problems will not be cured by more or better funding. We need a radical rethink about how social care is funded, provided and prioritised. To be genuinely sustainable, reform will have to be disruptive.

TYPES OF SOCIAL CARE

There are around 480,000 registered care home beds in the UK which care long term for service users 65 years and over. The number of beds available for use ('operating' beds) is around 3-5% fewer, because over the years many double rooms have been converted to singles but owners have not changed their registrations. Amongst operating beds more than half are privately paid for; the rest are funded by local authorities, the NHS, or jointly by NHS and local authorities. In addition, adult social care budgets fund people in extra care settings, close care and in their own homes. What is more, social care budgets are used to fund people under 65 who may have physical disabilities, learning difficulties, brain injuries and mental health issues, including challenging behaviour.

One reason for the strain on local authority budgets is that they have to cover not just the frail elderly, but these other groups too. And the demand for care in these groups has grown 3-4% in most years this century because many individuals in them now reach 80-90% of national average life expectancy and their ageing carers (often their parents) find it increasingly difficult to carry on.

The number of older people looked after by government agencies has declined over this period, due partly to rising incomes and tighter rules on needs assessments and the greater wealth of the 'baby boomer' generation. But these trends are changing in ways that add to the strain on budgets. The baby boomers are themselves starting to need support; families are saving less; pension changes in the last two decades are beginning to impact and a rising population is raising the demand for schools and other services that compete for local authority funding. As saving becomes harder for families whose incomes are now flat-lining and the cost of care continues to rise, so the difficulty of affording their own or their dependents' care has increased.

The local authority funding challenge, therefore, is much greater than is often realised. And there are other trends that pile on the pressure too.

DEMOGRAPHICS

On the demand side, the demographic trends are challenging. Between 2008 and 2018, the total number of people aged 65 or over in the UK rose by more than 2 million, partly because more people survive beyond pensionable age. Today, the total exceeds 12.1 million, around 18.3% of the population.⁷ There are now 292 people

⁷ Age UK, Later Life in the United Kingdom: <https://www.ageuk.org.uk/globalassets/age-uk/>

over 65 years of age for every 1,000 people aged 16 to 64. The greatest percentage growth is among those 85 years of age and over, who now number over 1.6 million.⁸

More than 2.2 million people aged 75 and over, mostly women, now live alone.⁹ A woman aged 65 can expect to live another 20.9 years, and a man another 18.4 years (though the increase in these figures has stalled since 2011).¹⁰ Disability-free life expectancy for a woman is 9.8 years, and for a man just 8.9 years.¹¹ In short, the extra years of life that people have today come with increased health and social care needs.

Moreover, huge variations still exist between those who are well off and those who are not. Better-off people can expect to live nine years longer than people living in deprived areas. Disability-free life expectancy is similarly skewed: women in the most deprived tenth of the country spend 34% of their lives in ill health, compared with only 18% in the least deprived. (For men, the corresponding figures were 30% and 15%).¹²

SOCIAL TRENDS

Social trends add to the funding challenge. More women are in work, meaning they face a significant opportunity cost by staying at home to care for family members. If they choose to remain in work, their earnings may be stretched to cover quality live-in care. Live-in care can cost upwards of £700 per week, while the average person in full-time employment earns hardly £550 per week before tax and national insurance.¹³

Declining marriage rates and easier divorce means that there are fewer couples remaining together into their 80s. In a third of those that do, one partner provides upwards of 35 hours of care a week for the other—a significant and increasing strain. Nor can elderly people rely on their children to care for them: fewer than one in seven elderly persons now live with their own children, and the majority do not even live near them.¹⁴

documents/reports-and-publications/later_life_uk_factsheet.pdf

8 ONS, Overview of the UK population: July 2017: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/july2017>

9 Age UK, Later Life in the United Kingdom: https://www.ageuk.org.uk/globalassets/ageuk/documents/reports-and-publications/later_life_uk_factsheet.pdf

10 Health profile for UK: <https://www.gov.uk/government/publications/health-profile-for-U.K./chapter-1-life-expectancy-and-healthy-life-expectancy>

11 ONS, Disability-Free Life Expectancy by Upper Tier Local Authority: UK 2012 to 2014, : <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/disabilityfreelifeexpectancybyuppertierlocalauthority/U.K.2012to2014>

12 Public Health England, Public Health Profiles 2020

13 ONS, Annual Survey of Hours and Earnings, 2017: <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/annualsurveyofhoursandearnings/2017provisionaland2016revisedresults>

14 Age UK, Later Life in the United Kingdom: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/later_life_uk_factsheet.pdf

The result is that the informal care that families provide is not keeping pace with the growing need. Although the number of carers is still rising (the latest estimate being over 6.5 million) there is a growing gap between those who have needs and those who can meet them. In fact, many people who are unable to cope with three or more activities of daily living are receiving no help at all from anyone. Often their accommodation is substandard anyway. In consequence, increasing numbers of people with social care needs present themselves in hospital A&E departments or become bed-blockers.

Perverse incentives do not help. People's homes are part of the means test for residential care, but not for care at home. NHS health care is free, while most social care must be paid for. This means there are strong incentives on local authorities and families to keep patients in NHS beds as long as possible—or get them into the NHS Continuing Care system, under which the NHS pays for their health care, social care and 'hotel' (food, accommodation and sundries) costs—something not matched anywhere else in the system.

CONSUMER ATTITUDES

Supply realities add to the challenge. It is difficult to induce people to buy an insurance product for social care that they have only a one in three chance of needing. Consequently, there is a lack of specially designed products for those wishing to provide for their own long term care. Moreover, insurers find it hard to equitably price 'catastrophic' risk. Somehow, risk must be pooled.

The 1999 Royal Commission Report on Long Term Care established a 'stealth tax' whereby private payers subsidise local authority service users by paying higher fees than local authority-funded residents for the same care in the same homes. This was never sustainable and is now ending as providers separate their self-pay homes from those providing local authority-funded care. Increasingly, self-payers are accommodated in newly developed homes while those with mainly local authority-funded residents suffer from a lack of investment.

The Dilnot Commission recommendations, which involved assessing every person's needs, were administratively cumbersome and open to legal challenges.¹⁵ They further suffered from a lack of support from the Treasury. They covered only the care element, not the 'hotel' costs. The remit did not address the lack of investment or the staffing shortages. Insurers and providers were unimpressed, and the politicians ultimately concluded that too few people would benefit. Yet one clear conclusion from the Dilnot report remains important: it is widely seen as unfair that, while most people can pass their homes and other assets on to their children, an unlucky few are forced to sell everything to pay for long term care.

FURTHER PRESSURES ON LOCAL GOVERNMENT PROVISION

¹⁵ Commission on Funding of Care and Support, 2011: https://webarchive.nationalarchives.gov.uk/20130221130239tf_/http://dilnotcommission.dh.gov.uk/

The key resource on which the care sector relies is its people. Yet new pension rules for part-time workers, and the introduction of the National Living Wage, have added to employment costs, while new immigration controls make it more difficult to recruit carers from overseas. Meanwhile, new rules that carers must be paid when travelling between appointments or on standby in the client's home add to the cost of at-home care.

Remember too that caring is a profession that people can easily leave. Many carers are on zero-hours contracts. The planned retention of more nurses in the NHS will also squeeze recruitment in the care sector.¹⁶ To retain good people, they must be properly paid. Providers too can very easily close down branches and walk away from contracts.

It seems possible, therefore, that capacity in the domiciliary care sector in the next five years could drop away quite quickly if local authorities can no longer fund the fee scales necessary to match these rising costs. The high likelihood of staffing shortages highlights the need to embrace radical change in the way care is delivered, such as using new technologies to make staff time more productive.

CARE AT HOME

Care delivered at home cannot continue as it is today. Needs testing rules for care at home (and in care homes) have tightened considerably since 2005. This tighter rationing, plus people's reluctance to place their parents in a care home and the cost of doing so, is prompting more families to pay for care in their own homes rather than in care homes.

But private care at home, either by ignorance or design, often flouts tax and employment legislation, and even basic health and safety rules. Families who are prepared to ignore, or do not know about, the National Living Wage and working time laws can hire one-to-one 24-hour live-in care for much less than the cost of a few daily hours of nursing and personal care in a care home that has to follow all the regulations and pay tax and National Insurance.

The standard of live-in care can be poor. The demands of being a 24/7 live-in carer do not attract many skilled people, especially if they are paid below the National Living Wage. In consequence, many have little or no training. Very few, including those funded by local authorities, have any qualification beyond NVQ2 or equivalent. They have no way of checking on the latest best-practice advice, nor do they play any part in plans for integrated care.¹⁷

¹⁶ The Government has noted that many of the additional nurses promised during the 2019 election campaign will be achieved by retaining existing staff in the NHS, see "Boris Johnson admits only 31,000 of Tories' 50,000 'more' nurses are actually new," *The Independent*, 2019: <https://www.independent.co.uk/news/uk/politics/boris-johnson-tories-new-nurses-promise-50000-31000-a9237676.html>

¹⁷ Covid-19 heightened this divide. In many cases, carers were not welcomed in because they had no PPE. <https://www.cqc.org.uk/sites/default/files/20200501%20COVID%201V%20update%20number%201%20ACCESSIBLE.pdf>

It therefore seems likely that, sooner or later, financial regulators will crack down on this informal economy. When they do, such care will become unaffordable to thousands of families.

THE NEED FOR NEW SOLUTIONS

To sum up, long term care faces the profound demand side issues of societal change, disincentives and the fact that people are unwilling to insure or save when they regard the system as an unfair lottery. These problems are compounded by the equally profound supply side issues of rising costs, regulation, budget pressures and the difficulty of paying and retaining quality staff.

This all suggests that, if a rise in cases of neglect is to be avoided, new ways of providing care must be found. We need to be much more inventive in giving people the incentives to fund themselves, in cutting the costs of care provision, in service redesign, in making insurance more attractive and in taking measures to provide better care and reduce the ‘hotel’ costs of care.

THE SOLUTIONS

Traditional solutions—such as the suggestion that social care should be predominantly provided by the state and funded, like the NHS, out of taxation—no longer look viable and are seen as unfair to younger generations. We need to be much more inventive in terms of:

- giving people the incentives to fund themselves;
- cutting the costs of care provision;
- product redesign;
- making insurance more attractive; and
- moderating the hotel costs of care.

Funding new care home provision

The social care debate has focussed on current systems of provision and how to make these sustainable and affordable to families, local authorities and taxpayers. There has been remarkably little thought about how more, better and lower-cost care might be provided—and by whom. Even before the virus outbreak, the current providers had no appetite to build care homes for the local authority-funded market, given the lack of any reasonable financial return on their investments.

However, the finance industry could be a viable option to fill the void for the future. Insurers and pension fund managers are always looking for assets to add into their investment mix. Their horizons are very long term, so they are willing to accept lower returns on investments that are secure and durable. With shopping going online and more people working from home, their traditional retail and office property markets are weak.

Yet there is a steady demand for new private care homes, and these in turn provide financial institutions with good and long term returns. What is needed is some way of overhauling whole the local authority care home sector. Much of the current building stock is more than 20-25 years old, and does not meet minimum standards in the legislation laid down for new homes, originally in the Care Standards Act 2000 (and updated in April 2007 and 2008) that require minimum room sizes of 12 sq. m. and 4.1 sq. m. day-space for every service user—and even larger allocations if the clientele are wheelchair users.

A practical solution would be to match the needs of the pension and insurance industries to the unsatisfied demand for new local authority care homes. Insurance and pension fund investors would commission new care home and extra care developments that they could lease long term (say for 25-28 years) to local authorities—enabling local authorities to provide for their caseload with long term security.

Investors would build the developments and lease them to the local authority, who in turn would put in the appropriate management (which could be profit-making or non-profit operators that met all parties' standards) to manage and maintain them. The local authorities would be buying a whole care package, not just buildings, over the lifetime of the lease, avoiding the large up-front costs of building new care homes for themselves. Each property would be transferred to the local authority at the end of the lease (at cost) or amortised over its life so the investors would recover their capital over a period of time.

Through this arrangement, the local authorities (singly or in groups) would receive good management and high standards. They could phase out substandard homes, many of which are conversions not suited for their purpose and expensive to maintain. Instead they could provide for the unmet demand in purpose-built homes that meet the specific needs of the frail elderly and those with dementia, some of whom have very challenging behaviour and whose needs are not the same. Because the returns are low on secure long term investments, the cost to local authorities would be contained. They could reduce it even further if they provided land from their own holdings for the developments. And by using standard designs, building methods and materials over a large number of care homes (perhaps ten or fifteen times more than the two or three that developers normally build now), construction and operating costs would fall considerably.

MAKING PRIVATE PROVISION AFFORDABLE

Nearly all of the debate on adult social care, particularly recently, has focused on care homes and on the funding of those who need them. But we need to consider the totality of care delivery before we can sustainably solve our current problems (and not least, how much is needed for better provision for the care of younger persons). We need to focus on fixing the present dysfunctionality of the entire system before any funding debate makes sense. Pouring more money into the social care system is like pouring more fuel into a corroded engine: without a major overhaul, it still will not get us anywhere.

THE NHS CARE OPTION

One of the most commonly heard suggestions is that social care should be rolled into the NHS and, like NHS care, be provided free at the point of use—possibly financed with a new ‘care tax’. To some extent, this idea is popular with the public. It would also allow better integration of healthcare and social services and would remove disincentives and unfairness.

However, the necessary rise in taxes or increased Government borrowing that would ultimately be paid for by the younger generations are less popular. Such a policy was in reality unaffordable even before the costs of Covid-19.

Though much social care is already financed publicly through local authorities or the NHS, most care services are delivered by independent providers. Merging care homes (even those just for persons aged 65 years or over) into the NHS would be the largest nationalisation since the 1940s, landing taxpayers with a compensation bill to owners as much as £20 billion, plus the additional substantial annual cost of running them.

The NHS, which already has one and a half million staff and is the seventh largest employer in the world, would see its employee numbers swell to over two million, making it even more difficult to manage than it is today. Yet it seems likely that social care would remain, in this new public enterprise, the poor, underprovided relation, alongside mental health care.

The proposal would not solve the fundamental problem that more than 75% of our care homes are old and no longer meet current standards—with narrow corridors and small rooms without en-suite bathrooms and often with insufficient day space. Even to maintain these homes to the present standards would require half a billion pounds of annual maintenance capital expenditure. More than 300,000 beds are increasingly obsolete but remain operative despite not meeting the minimum standards introduced by the last Labour government in 2001. At some point, additional money will have to be found to replace them.

It is questionable whether taxpayers would be willing to underwrite such large sums when only a third of them resort to social care at all. Furthermore, there would be a surge in demand if social care became free to everyone: for example, from the many families who are currently struggling to care for relatives themselves or to pay carers to look after them.

OTHER OPTIONS

It would be a mistake, therefore, to alight on the seemingly simple but flawed idea of making social care free at the point of use, as healthcare is. That is particularly true when there are other options, including ones that are already working in other countries.

For example, there is a proposal that taxpayers be allowed to set aside around £100 per a week, tax free, towards social care. This would allow individuals to accumulate enough funds throughout their lifetime to fund social care costs. The funds could be flexibly accrued or deducted and would allow multiple taxpayers to con-

tribute to a family member's care, giving families more freedom and autonomy back to the individual in need of social care services. Even so, the idea retains the basic unfairness of the current system, because, since there is no widespread pooling of risk, some families will retain their tax-free savings (to pass on to their children) while others will not.

Another option is something like Australia's nationwide aged care subsidies and supplements combined with substantial elements of user contribution.¹⁸ Australia's system provides a similar level of care to all individuals no matter their particular means. All individuals are expected to pay some part of their care. They also receive a minimum level of state funding. Those with lesser means receive greater state support. The Australian system also requires substantial but refundable bonds to help cover the hotel costs of care homes (also government funded if an individual has no assets). Unfortunately, it therefore also retains the basic unfairness of the UK system as there is no widespread pooling of risk. On the positive side, it gives families greater security and choice (far more than the current 'top up' arrangements in some regions of this country) and would end the stark divide between those who are fully state funded and those who are forced to pay the full cost of care—easing some of the perverse incentives and unfairness.

The point is that there is a world of options like these, and they all have their upsides and downsides. But we recommend that the government should at least look into the alternatives before it rushes to adopt solutions that don't actually solve all the challenges and inequities that exist in the current system.

NEW PARTNERSHIPS

We favour instead a new partnership between insurers, individuals and the state in terms of recapitalising the care home stock and helping people afford long term care more easily. Today, many people would like to pool with others the risk of care costs in future— as they insure against other risks—but they find the products limited and unattractive. There is only a (roughly) one in three chance of them needing the care, so they are tying up money that might not be needed. Also, they do not know how much to save, since they do not know how long their care needs, if any, might last. And there is less point in paying premiums when those who do not might get free care anyway.

Moreover, as we have seen, if insurers are to offer a reasonably attractive product, they cannot remain exposed to the 'long tail' risk—the risk that the insured person may be in a care home for many years.¹⁹

This is surely an opportunity for a new partnership. If people insured themselves for a defined period of care home care (say, six years) and the government promised

¹⁸ Australian Government Department of Health: <https://www.health.gov.au/initiatives-and-programs/residential-aged-care/funding-for-residential-aged-care/supplements-for-residential-aged-care> This system was designed based on Australia's Productivity Commission's report on 'Caring for Older Australians,' see <https://www.pc.gov.au/inquiries/completed/aged-care>

¹⁹ Dilnot Commission: <http://webarchive.nationalarchives.gov.uk/20130221130239/http://dilnotcommission.dh.gov.uk/>

to meet the costs beyond that, an insurance solution would become feasible and affordable. If more people were insuring, it would ease pressures on local authority budgets. And insured people could keep more of their own assets to pass on to their families, without the arbitrary spend-down limits imposed by government policy.

An insurance-based system, with the government as the long stop, would also help regularise the self-pay market. Insurers would charge one premium for a whole service, including care and hotel costs. They would insist on having clear contracts with known future costs—so clients would no longer be presented with unexpected cost increases after they had moved in. Insurers would also put a downward pressure on the level of fees, perhaps insisting that clients choose from a list of approved care home providers, just as healthcare insurers do. All in all, that would reduce costs for the government as and when it did have to step in and would very probably drive up standards as well. There is no reason why an insurance product cannot be developed for private home care as well.

REDESIGNING CARE AT HOME

Local authority-funded care at home is primarily delivered through independent providers.

At present, care at home is contracted on the basis of hours or number of inputs, with the focus on price rather than outcomes, and with no encouragement to integrate health and social care. This cannot continue in its present state. Local authorities should look in future to contract with the new generation of providers who are waiting to come to the UK, who have developed more sophisticated caregiver recruitment and training plans, and who employ the likes of blockchain and artificial intelligence (AI) in combination with Amazon’s personal assistant Alexa and Apple’s Siri—all the stuff of real transformational change. The regulator will also need to get up to speed with new technologies and adjust the rules accordingly: old red tape should not be left in place. AI will close many gaps in information and assist where human resources are limited. Significantly lower hospital readmission rates will be a further payback.

Developing insurance products for long term care will also be a catalyst for network building and technology enablement in this sector. We foresee that commissioners who currently know what they are getting elsewhere in terms of quality standards will want the same level of knowledge for the local authority home care sector.

The entry of insurers into the long term care sector would be a further catalyst for change that could enable all payers to have access to systems that demonstrate that all parties are receiving value for money and a quality product.

REBALANCING GENERATIONAL CONTRIBUTIONS

If more public funding is needed, we must think radically. Over the decades, more and more costs have been shifted away from elderly people and onto younger ones: Attendance Allowances, free TV licences, lower rates of National Insurance for persons over 60 years of age, Winter Fuel Payments—all these and more are costs borne by people of working age.

It would be fairer, and more efficient, to phase out some of these benefits so that older but wealthier people make more of a contribution to their generation's care costs. If it is a government priority to raise the £23,250 threshold significantly from its current level, then increased borrowings, a rise in national insurance (say for persons over 50, and the abolition of NI relief for persons over 60 years) would be an equitable way of funding this.

THE NEED TO RE-THINK

A more rational and affordable care system will involve disrupting the market. But the result of that disruption, through methods such as insurance and government cost sharing, or pension-fund financing of care home provision, will be greater supply, greater sustainability and greater fairness.

Public sector reforms are part of this: for example (as mentioned), NHS-funded Continuing Care creates perverse incentives and unfairness. Funding rules, too, produce other perverse incentives. If you go into a care home and your spouse is no longer with you, your residence is counted under means testing rules; but if care is delivered at your residence, it is not. Or again, (in another rule introduced by the Cameron government) the home is not included in means testing for care at home, while it is if care is to be provided in a care home. These examples (and others) distort local authorities' decision making.

The debate on social care has centred on how much more of it we can afford, either as individuals or as taxpayers. Sadly, that debate is pointless when the money we spend goes into a system that is largely dysfunctional. But with fresh thinking, it is possible to improve the quality of social care provision, to find ways of making it more affordable, and to rebalance service delivery more rationally between care at home and care in a care home.

In conclusion, an arbitrary boost to care budgets, and minor changes to the existing system will do little good and will not help long term sustainability. What we need are new partnerships in new markets that embrace fundamental change across the board, improved transparency and better integrated health and social care.