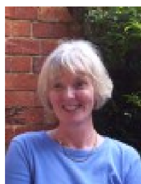
Reforming funding is vital, but changing the nature of social care, how it is delivered, and what it can achieve is a far more substantial challenge



Melanie Henwood *discusses the Prime Minister's plan to reform funding for adult social care through an increase in National Insurance. She writes that the government needs to be ambitious in addressing the support needs of people of all ages, and also needs to invest in prevention, recovery, and reablement services that reduce the need for residential care.*

Ever since Boris Johnson's election in 2019, when he pledged to sort out the problem of social care 'once and for all' with a plan they had 'ready to go', there has been an extended hiatus and silence on the shape of reform. Finally, the Prime Minister's announcement on the reform of funding for adult social care has been made and brought few surprises. A 'Health and Care levy' is to be introduced through a 1.25% increase in National Insurance to provide a hypothecated tax generating some £36 billion 'direct to health and social care'. The regressive nature of National Insurance has been highlighted by many, including Conservative MPs who opposed tax increases. To some extent, this has been ameliorated by extending the levy to older workers and to dividend income, but many would argue that increased income tax would have been a fairer basis.

The long-anticipated solution will not be greeted with great enthusiasm or relief among many in the health and social care community, but more with a disappointed sigh over the lack of ambition and apparently narrow understanding of social care. We've been here before, indeed repeatedly so over the last 25-30 years and the litany of inquiries, of Green and White Papers, and even legislation in the 2014 Care Act is familiar to social care commentators, and should have resolved the key funding issue years ago. The Dilnot Commission report of 2011 identified the fundamental flaws in a system that was 'confusing, unfair and unsustainable', and proposed a cap on lifetime care costs and significant raising of the means-testing threshold. The cap was central to the 2014 Care Act, but implementation was 'delayed' by the incoming Conservative government in 2015 before being permanently ditched. The fact that this is once again being debated and reforms proposed is testament to the intransigence and complexity of the issues, and – above all – the lack of political courage of successive governments to resolve the central question of who should pay for long-term care.

The debate is easily hijacked by critics who argue that this is all about protecting the housing equity of wealthy older people, and ensuring the inheritance of their children. Indeed, that argument has been made frequently in recent days by pundits apparently eager to drive a wedge between generations and to argue that older people are somehow less deserving of support than others. It is also a fundamental over-simplification of the challenge that obscures reasoned debate or understanding, and fails to recognise that the greatest costs of social care are currently through funding the support of younger disabled adults, not older people.

The issues will be familiar to many, but need to be re-stated. First, health and social care operate on a different basis and have done so since 1948. While health is paid for out of general taxation and is largely free of charge at the point of need, this is not the case with social care, which is funded by local government and is means-tested. Many people do not understand or know anything about this distinction and its implications until they collide with the system when they or family members need care. Second, the boundary between what is health and what is social care has shifted over time with the closure of many long-stay beds in hospitals and their relocation in residential care sector beds – essentially a move from a free system of care to a charged one. Third, the means-testing net trawls very deep and draws in not just people of substantial net wealth, but people of relatively modest means – currently anyone with more than £23,250 in assets including the value of their home if they own it must meet the full costs of their care.

Often the reason why older people need residential care is because of cognitive decline and dementia, and this is the lottery of social care. Not everyone gets dementia (an estimated 2% of people aged 65-69 and one in five of those aged 85-89), and most of those will not require full-time residential care. But for those who do, these costs are substantial, unlimited, and potentially catastrophic as people can lose their entire accumulated assets as they spend down to the floor of £23,250. One in ten people aged 65 face future care costs of more than £100,000.

The Johnson proposals for reform substantially raise both the floor and ceiling of financial liability; no one should face more than £86K lifetime costs, and the upper limit for full liability will be raised to £100,000, with contributions means-tested on assets between £20,000 and £100,000. The reforms are overdue and as the Prime Minister announced: 'governments have ducked this problem for decades'. His solution claims to offer an answer to multiple pressures in both the health and care systems. His statement began by focusing on the NHS and the need to introduce 'the biggest catch-up programme' to support the health service in recovering from the demands of responding to the pandemic, to increase hospital capacity by 110%, and by treating 30% more patients by 2024/25 than before COVID-19. How the resources are to be shared between health and care is much less clear, and the demands of the health service will be significant as services are stretched to catch up on elective procedures and treatments that have built up since spring 2020.

Having a fairer approach to funding will help alleviate the catastrophic and unlimited costs that people can face for care (although they will stay pay for their 'hotel' costs), although in practice many people will not live long enough in residential care to see any benefit from capped costs. What is much less clear is how the funding will also enable older and disabled people, as the PM claimed, 'to be cared for better and with dignity'. To do so requires huge investment in the care workforce to provide better wages to recruit and retain care workers, but also a cultural change in understanding the objectives of social care and the outcomes it needs to achieve in enabling people to live better quality lives and to support independence. The proposals also offer nothing to those people already paying for care and facing the continued worry of running out of funds; the reforms will not take effect until 2023 and for many people this will be far too late.

The debate, and the Prime Minister's announcement, have been framed almost exclusively as if social care and residential care are synonymous when they are not. We have to be ambitious to address the support needs of people – of all ages – and crucially to invest in prevention, recovery, and reablement services that reduce the need for residential care and enable younger disabled adults, as well as frail older people, to have choices and quality support in the community. The reform proposals do not appear to set out how this much wider agenda and vision will be achieved. Reforming funding is vital, but changing the nature of social care, how it is delivered and what it can achieve is a far more substantial challenge that remains far beyond the current horizon.

About the Author

Melanie Henwood is an independent health and social care research consultant.

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