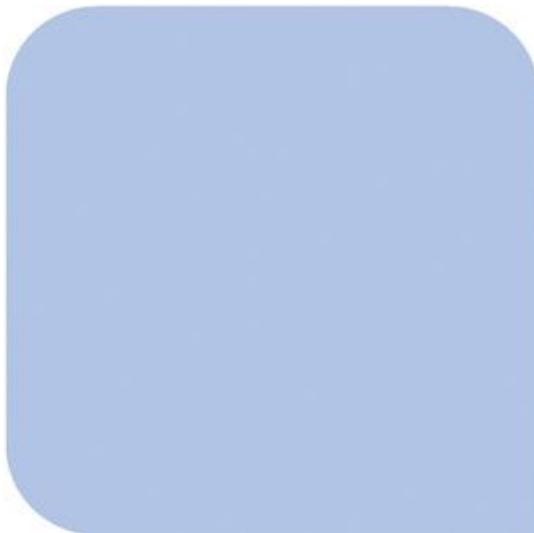


Call for evidence on the future funding of care and support: Response from the Social Care Institute for Excellence

January 2011



SCIE has no objection to this consultation response being made public.

social care
institute for excellence



Key messages

1. SCIE broadly agrees with the Commission's description of the main challenges and opportunities facing the future funding of care and support. Questions of *how* to fund care and support cannot be wholly separated from *what* to fund, and patterns of provision are changing and diversifying, not least as a result of progress in implementing policies of personalisation, choice and control. Solutions to the problems of funding future demand will not be found by focusing only on adult social care budgets, and require a cross-sector approach that takes account of interactions between social care, health care, housing, transport, leisure, education, training, employment and benefits funding. In addition, the scale of the care and support provided by family carers is so large that it should be explicitly factored into the resourcing equation in order to achieve a sound understanding and analysis of the total care and support system.

2. This SCIE response examines a range of factors, including:

- demographic pressures
- unmet need
- anomalies in patterns of state-funded provision
- the balance between residential and domiciliary care
- the growing proportion self-funding their care and support
- the use of direct payments and personal budgets
- pressures on informal and unpaid carers
- the potential contribution of new technology.

Within the overall demand for care and support, which will clearly continue to grow at a significant rate, there is already a considerable degree of segmentation. Key groups include those (mostly disabled working-age adults) receiving support fully funded by the state, those means-tested and charged, users of direct payments and personal budgets, self-funders, and people reliant on spouses, relatives and friends for unpaid care and/or financial help with care costs. Each group presents different issues in terms of their relationship to the system of state funding. The broad demographic forecast needs to be subdivided and analysed along similar lines to gain a fuller understanding of the implications for provision and funding of care and support, and the costs and benefits of different ways to invest the state's contribution.

3. This response contains a commentary on the strengths and shortcomings of the present system as set out by the Commission. SCIE would agree that the factors identified as strengths should be carried forward into any reformed system. These include safety net provision, personalised approaches giving people choice and control, a focus on prevention, partnership working between

individuals, families, the state and private sector, and responsiveness to local needs. However, the Commission's account of these features is somewhat optimistic in places. The 'safety net' may not be large or strong enough to accommodate all who would fall into the 'lowest means and highest needs' definition. The policy emphasis on prevention is not matched with dedicated resources, and these will be further squeezed by the reductions in public spending. Prevention also requires a coordinated approach across service boundaries, and this is lacking in many areas. The 'partnership' of individuals, families and the state frequently operates on an unequal basis, particularly for people judged ineligible for state support in a period of tightening eligibility criteria. The Commission identifies the fine line between local responsiveness and a postcode lottery, and the current span of variation in levels of provision and charging is hard to justify.

4. The Commission points out a range of shortcomings in the current system. These include very high care costs and loss of income and/or assets for some, rising levels of unmet need, steeply rising unit costs, tighter eligibility criteria, increasing and potentially unsustainable demands on carers, issues of value for money, cost-effectiveness and overlapping public funding streams, low understanding of the system as a whole, and perceived unfairness by a range of criteria. SCIE's response endorses this account of the shortcomings and provides detailed comments on some aspects. There are clearly issues about securing the best, most cost-effective and efficient use of resources provided from public funds, but many of the shortcomings reflect a fundamental resourcing issue. High care costs imposed on people's income and assets are particularly unfair in the case of people who need lengthy periods of care, such as those with dementia and other long-term conditions, and raise questions about the boundaries of funding responsibility between social care and the NHS. Tighter eligibility criteria and increased charges for domiciliary care are obvious, if ultimately counterproductive, ways for local authorities to manage rising demand and shrinking resources. Increased flexibility in patterns of service provision and use, and applying personalisation and co-production approaches to secure the best mix of formal, informal and community support, are two ways to make better use of limited resources, but they are unlikely to be sufficient on their own to bridge the funding gap. SCIE shares the Commission's concerns about pressures in the system placing excessive demands on carers, and considers there is a sound economic case for substantially increased investment in carer support.

5. The Commission invites suggestions for how, in response to the trends and shortcomings identified, the funding system should be reformed. As noted earlier, SCIE's view would be that reform of the care and support funding system cannot be separated from continuing development and modernisation of patterns of provision and resource use, including new technological applications. The challenges also have to be seen in the wider inter-agency context of changing service and resource patterns in the NHS, housing, LA services, training, employment and benefits. Priorities for additional investment

include expanding and strengthening home care, development of a comprehensive carer support system, releasing resources for flexible use in self-directed support and personal budgets, and equipping the paid and unpaid workforce to meet new requirements and expectations. Care and support funding for the various groups of disabled working-age adults needs to be addressed in the broader strategic context of independent living policies, enabling them to access mainstream training, employment and housing opportunities, strengthening their position as citizens, securing their human and civil rights and removing the sources of discrimination and other obstacles to full social participation.

6. For the large and growing numbers of older people with often complex health conditions requiring varying degrees of care and support, the strategic issue the Commission faces is whether the current system is irretrievably broken and needs replacing, or whether it is capable of sufficient reform to be fit for purpose over the next 10–15 years. This response suggests a wholesale replacement may have as many drawbacks as benefits. Key improvements to the current system, in addition to a significant injection of new funds to address current and forecast shortfalls, would include fairer charging systems, a more positive contribution from the finance industry, mainstreaming of innovations in self-directed support and co-production, stronger inter-agency frameworks supported by local Health and Wellbeing Boards, and development of outcomes-based care and support approaches designed to maximise productivity and choice.

Introduction: SCIE's role and the wider policy context

1. The Social Care Institute for Excellence (SCIE) is pleased to respond to the Commission on Funding of Care and Support's Call for Evidence on the Future Funding of Care and Support. SCIE's mission is to identify and spread knowledge about good practice to the large and diverse social care workforce, as well as policymakers, educators and the research community, and to support the delivery of transformed, personalised social care services. We use various methods and media to reach and influence practitioners, managers and the sector leadership who have responsibility for service delivery in adults' and children's services. We recognise the central role of people who use services, children, young people, their families and carers, and we aim to ensure their experience and expertise is reflected in all aspects of our work.

2. SCIE works to:

- *capture* and co-produce knowledge about good practice. We carry out and commission research and work with other leading organisations to produce information and practical guidance about what works in social care
- *communicate* knowledge, evidence and innovation. We share our knowledge about what works in partnership with sector partners including improvement agencies, networks of providers, groups of people who use services, including children, young people, their families and carers, regulators and government departments.

3. Ultimately SCIE aims to be a *catalyst* for the transformation of care services. We believe that the knowledge and guidance we provide will inform and inspire improvement. Only by understanding what works in practice – and what does not – can services be improved, and the status and capabilities of the workforce raised.

SCIE response to issues raised in the call for evidence

4. **The main challenges and opportunities facing the future funding of care and support:**

- The Commission identified a series of demographic and other challenges to the care and support system. Demographic changes over the next 20 years include: a 50 per cent increase in people over-65; 300 per cent increase in those over-90; a resulting 66 per cent increase in demand for care/support from older people; 30 per cent increase in working age adults with learning difficulties; OBR forecast that government spending on long term care will increase from 1.2 per cent to 1.7 per cent; demand for care from adult children will grow by 55 per cent, but supply by only 13 per cent.
- It is not easy to forecast precise patterns of needs, assets, or technological change. Some key factors identified by the Commission are as follows:

- About half current Personal Social Services (PSS) spend on older people is on those over 85. About 60 per cent of state PSS spend on working age adults is on people with learning disabilities.
- There is mixed evidence on likely future change in age-specific prevalence rates of disability and disease patterns.
- Older people and disabled working age adults have very different asset and wealth profiles – median household wealth of an employed person is 217k, whereas that of a disabled person is 21k.
- The care system needs flexibility to accommodate likely impact of new and changing technology.
- Reformed funding system must be resilient to changes in pressures, demands, expectations, individual/family/community circumstances.

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

5. The paper is clear about the major *demographic changes* in prospect, and the scale of increased demand they imply which the reformed system has to meet. The estimate of a 66 per cent increase in demand as a result of a near-tripling of the number of very old people seems modest. It implies some heroic assumptions about improved health and fitness amongst older people, and substantial confidence in the success of public health programmes in stimulating healthier lifestyles and greater independence. Within the national picture, there will be regional and local variations in patterns of need and demand, in local traditions, cultures, service mix and priorities, as well as other variables stemming from factors such as ethnicity and diversity.

6. The paper also acknowledges, without being able to quantify in detail, the likelihood of existing *levels of unmet need*. It infers shortfall, as Wanless did, from the failure of resource growth to keep up with population increases over recent years. Raising eligibility criteria under the FACS framework, as has happened over recent years in most councils as a way of managing rising demand, also has the effect of masking unmet need. The former care regulator, the Commission for Social Care Inspection (CSCI), examined in 2007 the outcomes for people deemed ineligible for publicly-funded services because they did not meet local FACS criteria, and found that councils made relatively little effort to follow up this group and record their outcomes. This is unlikely to have changed since. CSCI also asked the PSSRU to estimate levels of unmet need from the available statistical data and this report was published in 2007.¹

7. Statistical analysis by the NHS Information Centre of LA-funded residential and domiciliary care might suggest some anomalies in present *patterns of resource*

¹ Self-funded social care for older people: an analysis of eligibility, variations and future projections. PSSRU Discussion Paper 2505. October 2007.

allocation. Supported residents in residential and nursing home care numbered 229,900 in 2009, a 3 per cent reduction on the 2008 figure which continued a steady decline from 2003. 326,000 households were receiving LA-supported home care in 2008. In other words, local authorities were supporting only 42 per cent more households with home care than the numbers they supported, at significantly higher costs per head, in residential and nursing home care. This could be interpreted, and has been in DH policy documents, as an over-investment in residential care. It could equally be indicative of a cumulative under-investment over 10–15 years in home care.

8. On the face of it, the continuous reductions over more than a decade in the numbers receiving *local authority-funded home care*, at a time of steady increases in the older population and therefore in age-related disabling conditions and dependency-levels, appears somewhat counter-intuitive. The NHS IC age-breakdown of LA-supported residents also raises some interesting questions. 93 per cent of admissions to residential and nursing home care in 2009 involved people over 65. The rate of admissions of people over 65 per 100,000 population fell by nearly a quarter between 2003–4 and 2008–9, from 974 to 738 per 100,000. This downward trend does not appear to support the view that residential care is being used too freely. On the other hand, at 31 March 2009, only 42 per cent of LA-funded residents were over 85, with 25 per cent between 75 and 84, and 10 per cent between 65 and 74 (with the rest under 65).

9. It is hard to interpret these *residential admissions* figures definitively without further detail, but they suggest a number of possibilities. One is that significant numbers of the 'younger old' are being admitted to residential and nursing home care who might have been maintained at home if home care services were more extensively available. Another is that dementia levels are high in this cohort, reducing the capacity to manage, or be supported, at home at markedly younger ages. The third possibility is that, whatever the reason for relatively early admission, the turnover of younger residents in care for older people is less than that for those over 85. Overall permanent admissions of over-65s in 2009 were 62,500, 27 per cent of total LA-funded places.

10. Another important element in the equation *is the number and proportion of self-funders*. The Institute of Public Care at Oxford Brookes University has drawn together available data². Estimates for the proportion of care home and nursing home places occupied by self-funders range from 33 per cent (Wanless) to 37 per cent (Forder) to 41 per cent (Laing and Buisson) to 44.9 per cent (IPC). There are also known to be large regional and local variations in the proportion of self-funders. The picture is further complicated by a) the number and proportion of local authority-funded placements which also receive third party top-ups; b) proportion of people crossing the threshold from self-funding to LA-funding as their resources are depleted and c) the percentage of services funded under NHS continuing care arrangements.

² People who pay for care: quantitative and qualitative analysis of self-funders in the social care market. PPF Consortium. January 2011.

http://www.puttingpeoplefirst.org.uk/library/Resources/Personalisation/Localmilestones/People_who_pay_for_care_-_report_12_1_11_final.pdf

11. Reliable information on people *self-funding home care*, both personal care and practical help, is even more sparse. Some will go through the council assessment process and be turned away because they do not meet the eligibility or means-testing criteria. But others make and fund their own arrangements, or a relative does it for them, and may not come to the notice of the local authority at all. Anecdotal evidence suggests that in more affluent parts of the country some 50–80 per cent of new entrants to residential care are funding that care themselves.

12. In parallel to the IPC data study, the Putting People First consortium (Local Government Group and ADASS) and SCIE commissioned Melanie Henwood Associates to undertake a *study of self-funders* ('Journeys without maps'³) which involved interviews with samples of service providers, self-funding service users, and carers. Some of the findings were:

- Entry into the care system almost always took place in crisis situations, often as a result of catastrophic change for the individual such as loss of a spouse or a disabling fall. Hardly anyone felt they had chosen to accept care, or been part of a genuine decision-making process.
- Pressure from hospitals for speedy discharge, and concern on the part of relatives about the person's fitness and ability to manage at home, added to the sense of emergency and the demand for decisions at short notice, with little time even to visit and judge the suitability of nursing or care homes.
- The individual and relatives generally experienced great difficulty in securing sound advice about service options and independent financial advice. Local authorities when approached were often reluctant to give advice on the quality of independent sector provision, and the regulator – the Care Quality Commission – has moved away from the previous rating system for care services.

13. Henwood's comment below suggests that effective intervention and advice at such points of crisis could increase people's options and scope for decision-making, and reduce pressure on the care and support system:

'It is clear that having sufficient resources to be a self-funder does not automatically give people greater control over their situation, and meaningful choices are often lacking.There was a profound sense throughout the project of people undertaking major life journeys without the benefit of maps to guide them, and with no clear sense of their destination. In many ways people who were self-funding were considerably disadvantaged, relative to people qualifying for publicly funded support, by not having access to independent assessment of their needs (as opposed to their means), or to clear information about their options, and care advocacy to help them in achieving their preferences. For people who were without a close family

³ People who pay for care. Ibid.

member to help them on their journey, the options were fewer still and the path a lonely and bewildering place to navigate.’

14. A further category includes those, both working age disabled adults and older people, who meet their council’s assessment criteria and opt to use *direct payments or other forms of personal budget* to arrange their own support package. This number is known, and growing, and represents a significant element in the changing pattern of service commissioning and provision with important implications for future funding models. As noted above, the issues of funding reform cannot be wholly separated from questions of *what* is funded. Direct payments offer not only greater scope for self-directed support and innovative, personalised care packages, but also flexibility to blend funding from social care, employment support, benefits and pensions with people’s own personal resources, help from carers, and neighbourhood and community support. The Government’s Big Society proposals envisage a larger and stronger role for support of this kind.

15. The Commission’s paper recognises the essential contribution of support from *unpaid carers*, mostly spouses, adult children, other relatives and friends, to the care system overall. It does not attempt to quantify its current scale, although others have sought to do so. Whilst there is some controversy about how best to monetise the value of informal and unpaid care, most commentators accept that its replacement cost would dwarf current public spending on adult social care. They also suggest that, compared to the return on investment in other prevention services, investment in measures to sustain carer support offers very substantial benefits in relieving demand for and pressure on statutory services.

16. The paper shows explicitly the projected growing gap between the increased demand for *carer support from adult children* and its likely availability. It also acknowledges by implication the dependence of the formal health and social care system on the contribution made by carers. If that were to be significantly reduced, or collapse through unsustainable pressure on carers, the formal services would quickly face severe problems. This strengthens the case for a serious examination of the interface between formal and informal care and support, and the scale of investment required and warranted to provide carers with proper back-up. The Scottish Executive has done some work on this issue.

17. The full potential impact and contribution of *new technology* such as telecare and telehealth and advice services, has only begun to be explored. It could be beneficial to both working age adults and older people requiring care and support, in helping to personalise and connect up the support they can access from a range of formal services, family and community networks. Other applications could benefit carers, in enabling more flexibility in their support arrangements, and address the difficulties noted earlier in obtaining sound information and advice on care and support options.

2. Strengths and shortcomings of the present system

18. The Commission identifies as key strengths of the present system that it provides a safety net for those with lowest means and highest needs; supports personalised

approaches giving people more choice and control; focuses on prevention to defer/avoid further deterioration; operates on a partnership basis between individuals, families, the state and private sector; and is able to respond to local needs. A reformed system should retain these features, whilst giving carers more support and avoiding an unwarranted postcode lottery.

19. It recognises that different people have identified a variety of shortcomings in the current system. Some people face very high care costs, whether for residential or intensive domiciliary care, and may lose most of their income and assets. It is likely there are significant and rising levels of unmet need. The market in private financial products is underdeveloped, unit costs of residential care for older people and working age adults have risen steeply over past five years, and eligibility criteria have tightened over same period. There are increasing demands on carers. Questions arise about whether current spending delivers value for money, about how cost-effective traditional interventions are, about overlaps between different public funding streams and about ways to promote joint investment in health and social care. There is low understanding of the system as a whole, but it is perceived as unfair by a range of criteria. The reformed system should be designed to deliver equalities and human rights

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?

Strengths

20. The Commission is perhaps too optimistic in claiming the present system 'provides a *safety net* for those with *lowest means and highest needs*'. The safety-net has become increasingly stretched and fragile in many places as social care resources have failed to match growing demand. Most councils have raised eligibility criteria in recent years as a means of rationing, so the definition of 'highest needs' is determined by resources, and excludes many with substantial needs for personal care, practical help, social contact and psychological support. Even within the 'critical needs' definition, life and limb considerations receive priority over those to do with sustaining engagement in employment, education and family life, and this disadvantages working-age disabled people. Determination of those with highest needs is further skewed by local NHS hospital discharge pressures.

21. It is likely that significant numbers of people are *diverted at early stages* from the local authority's assessment processes. The revised DH guidance on Fair Access to Care Services, issued in 2010, made it clear that people are entitled to have their needs assessed and receive advice on options before means-testing is applied. Nonetheless, the practice persists of advising those above the capital limit that there is no point undergoing assessment because it is obvious they will not qualify for publicly-funded help. This was confirmed in most of the interviews with self-funders and relatives in Melanie Henwood's report quoted earlier.

22. Policy support for focusing on *prevention* is not necessarily matched in levels of resource allocation or practice priorities. Teams under pressure respond to demands for assessment, provision of care and support, and adult protection referrals. There is a shortage of resources dedicated to prevention and early intervention in many, if not most, authorities. Pressures on the system produce perverse incentives to wait until people's and their carers' situations are near or at breaking point before intervening. This is an area that would benefit from much more co-ordinated investment from social care, the NHS and voluntary and community services. As noted earlier, information and advice services are seriously underdeveloped in most councils, and people are entering residential care for lack of knowledge of practicable and available alternatives. Henwood questions whether the local authority is the right vehicle for providing information and advice services, because of their perceived preoccupation with gatekeeping and operating rigorous eligibility systems.

23. It is true that a strength of the current system is its ability to *respond to local needs*. As well as the associated risk of an arbitrary postcode lottery for individuals, however, there is also the problem that current and historic patterns of provision of related services – health, housing, training, employment, transport, leisure – may distort demand for care and support. The need for the “safety net” can be significantly affected by the availability or otherwise of extra-care housing, employment opportunities for disabled working age adults, community mental health services, and transport and leisure schemes for older people. The volume of NHS long-stay provision has reduced for older people, including those with dementia, and disabled adults, particularly those with more severe levels of learning disability and mental health difficulty. There are indications of significant shifts over time in the boundary between NHS and social care, placing increased demands on the care and support system and not always accompanied by comparable transfers of resources.

Shortcomings

24. A general shortcoming of the present system is the dominance of three or four *traditional forms of service provision* – residential care with and without nursing support, home care, buildings-based day services – with too little interchange or flexibility between them. The result is a rigid service system, not easy to adapt to the requirements of individuals and their families, and lacking incentives for adaptation and innovation. There has been a disappointing failure of local pilots and other initiatives to enter the mainstream. A better understanding is required of the diffusion of innovation.

25. Thinking has also tended to be dominated by a perception of rigid service blocks, rather than by the possibilities of a *flexible spectrum of services* more capable of responding to individual choice and control. Residential care, for instance, has often received negative references in policy documents, minimising or ignoring the considerable scope for creative partnership working between residential homes and hospitals, reablement and home care services, and community support networks. Poor co-ordination of funding streams and regulatory requirements can put obstacles in the way of such developments.

26. Amongst those facing *very high care costs*, particular concerns have been raised about the position of people with medium and severe levels of dementia. A majority of people living, not just in specialist dementia provision but in general residential care, suffer some degree of dementia. Stephen Dorrell, Chair of the Health Select Committee, has strongly questioned the fairness of people requiring care because of a diagnosed health condition being means-tested to pay for it, when equivalent care, albeit in less satisfactory and homely hospital provision, would in the past have been available free.

27. In relation to *more intensive home care*, it is worth noting that the DH definition of 'intensive' is 'more than 10 hours care per week and more than 6 visits per week' – not a particularly high level of support across a 168-hour week. In 2008, out of a total 328,600 households receiving LA-supported home care, 105,000 (32 per cent) received 'intensive home care'. It is notable that this level of 'intensive' home care has been achieved at the cost of consistent year-on-year reductions in the overall numbers receiving LA-funded home care, in sharp contrast to the demographic trends over the same period. Local authorities also have greater discretion over the level of charges they apply to home care than to residential care, where charges are set nationally. Some authorities have signalled substantial increases in charges as a means of managing forthcoming funding reductions. A recent Consumer Association report has also highlighted wide variations in council charges for home care, and in some cases very high hourly charges.

Unit costs, value for money, overlaps in public funding streams, cost-effective interventions

28. *Value for money and cost-effectiveness studies* in adult social care are still relatively limited, and have not yet had more than a marginal effect on policies and provision. This partly reflects the early stages of developing ways to define and measure "value", "effectiveness" and outcomes from the perspective of people using services, their family carers and the wider community. It may also be affected by the conceptual difficulties involved in connecting outcomes to the complex network of funding streams and possible services operating in this territory. A better understanding of cost-effectiveness is highly desirable, not least as a vehicle to generate diverse options for achieving the same ends. SCIE is currently developing its methodological capacity to assess the cost-effectiveness dimension of interventions and services (where the evidence is available) and is building this dimension into its work. A recent overview report into the current evidence base on efficiency and personalisation is an early example of this approach⁴.

29. With that caveat, *judgements about value for money* and cost-effectiveness are influenced by the comparators chosen. Policy guidance, National Indicators and so on have sought to reduce the proportion of council social care budgets spent on residential care. Evidence is emerging that intensive home care may not be much less expensive, and indeed more costly on a net basis when the charging element is factored in. On the other hand, a residential care place is substantially less expensive than a hospital bed, and may therefore represent very good value for money to the local health and care

⁴ Report 37: Personalisation, productivity and efficiency. SCIE. London. December 2010.

economy. Whilst reablement may not always deliver claimed levels of cost-benefit, not least because of the way different forms of reablement are staffed, the evidence suggests it is likely to be a worthwhile investment and lead to increased personal independence longer-term⁵.

30. Local authorities as commissioners have, unsurprisingly, found it easier to focus on *price and volume* rather than specify value as represented by outcomes. Some have developed sophisticated and effective tendering processes, working in conjunction with expert providers, ensuring the involvement of people using services, and protecting maximum user control and choice. Others are reported to use much cruder approaches, operating “preferred provider” lists which severely restrict user choice or, in the current climate of financial constraint, simply notifying care providers of 10 per cent or higher cuts in fees, without either negotiation or acknowledgement of the impact on residents’ quality of life.

31. *Unit cost* information needs to be interpreted with care. As with the NHS, there are strong upward pressures on unit costs of residential and nursing home care. The average cost per adult aged 18 and over supported in residential care, nursing care or intensively in their own home was £593 in 2008–09, an increase from £559 in 2007–08 (6 per cent in cash terms and 3 per cent in real terms). These average figures conceal significant variations. The cost of nursing home care for older people (£493) per person per week is similar to that for residential care (£498) but the cost for LAs’ own residential care provision (£824) is higher than the cost for residential care provided by others (£445). Similarly, the average cost of home care on a sample week basis was £14.60 per hour but the cost of LA- provided home care (£23.20) was higher than that for home care provided by others (£12.60). These differences may, in part, reflect differences in the types of client cared for and in accounting procedures; they also reflect the relatively poor pay, pensions and other conditions in the independent (private and voluntary) sectors.

32. The unit cost of providing residential and nursing care to *adults with learning disabilities* has increased by 7 per cent in cash terms and 5 per cent in real terms, from £1,047 per person per week in 2007–08 to £1,125 in 2008–09. The substantial difference in costs of residential care for an older person and a learning disabled adult is in part a product of explicit government policy through the 1970s and 1980s, that residential homes for the latter group should be smaller and more homely in scale than homes for older people. Most offered 16–20 places compared with 40–60 or more for older people, thereby foregoing significant economies of scale.

33. *Demands on carers*. Figures from the General Household Survey indicate that roughly 1.75m of the 2m disabled older people in private households receive informal care, mainly from a spouse or an adult child. Census data show that significant numbers of people are providing care for more than 50 hours each week. There is evidence that individuals who provide more than 20 hours of care per week, particularly to a partner,

⁵ See SCIE’s emerging practice messages on reablement at <http://www.scie.org.uk/adults/prevention/files/reablementemergingmessages.pdf>

show a statistically significant lower quality of life than equivalent non carers, and can find the demands damaging to their health, wellbeing and standards of living. The carer's availability can also reduce the individual's chances of receiving care and support. Disabled older people living alone are more likely to receive care services than those of similar age and disability living with a spouse or married couples getting help from adult children. The revised Fair Access to Care Services framework, issued by DH in 2010, requires eligibility assessments to consider whether current levels of input from carers can be sustained, but the assessment does not entitle carers to any support in their own right. Carers' support services are provided at the discretion of each council, and there is wide variation in whether and what services are supplied. The case for providing adequate support to prevent a caring arrangement breaking down seems self-evident.

3. Priorities underpinning reform proposals, and requests for further evidence

34. The Commission identifies four underpinning priorities in order to recommend a sustainable settlement:

- People should have the opportunity to be protected against the future costs of care and support – but there are few current mechanisms for risk-pooling, risks of needing care and support are hard to define and measure, start and duration of need for care are hard to predict, and cover is hard to price.
- People need to understand how care and support system works, in order to be motivated to plan accordingly.
- People need to be clear about role of wider system, including the NHS and benefits entitlements, in supporting older people.
- Increased resources will be required, from all sources, to accommodate demand pressures and meet needs for improved outcomes.

Comments

35. Better public understanding of the current system for care and support, and how it relates to the wider NHS and benefits systems, is clearly a good thing to promote. Whether, if people understood more fully what care in old age costs, and that it is not provided free by the state, they would be strongly motivated to seek and pay for insurance-based protection at earlier stages in life is a matter of speculation. If so, presumably the insurance industry could come up with solutions to the problems of risk, duration and pricing, which must be common to much of its business. Henwood, interviewing self-funders and relatives however, found that hardly any had thought about or planned for care needs before a crisis precipitated the urgent need for a care solution, and only at that point did they become aware of the high cost of care. Shifting this mindset will be a major cultural challenge.

36. Much would depend on:

- How seriously people judged the risk to themselves of needing care – many men, advised at 65 that they had a 1 in 5 chance of needing care at some time in the future, would think this a risk worth taking.
- How far they trusted the insurance companies and the reliability of their offer – ‘need for care’ is not an objective fact, like subsidence or a car repair, but a matter of judgement and relative eligibility.
- How favourably they judged the relationship between premium and cover – many of the conditions likely to lead to the need for care are precisely the factors which might lead insurers to exclude people from cover or to cover only at very high premia.
- Whether risk-pooling carried an element of compulsion, to spread risk more evenly and reduce costs to individuals – if not, how participation might be incentivised through the terms of insurance, the tax system, matched funding from the state, or other inducements.
- Whether a scheme for protection of assets might have attractions for the potential heirs of the individual receiving care, and attract them to invest.

37. The last of the priorities is welcome recognition that the scale of projected demographic growth, unmet need and inadequate quality is too great to accommodate within existing levels of resources. The challenge to efficiency, productivity and innovation is substantial, and ways need to be found of maximising the resources of the care system, freeing the talents and creativity of the workforce, and enabling people to work with care professionals on the basis of co-production to develop their own personalised solutions. Beyond these measures, however, the issue is how a wealthy advanced society makes reasonable provision for its ageing population. What proportion of public spending should be earmarked for this purpose?

38. The Commission requested more evidence on:

- length of stay in residential care
- risk of needing care
- measurement of unmet need
- demand for formal care services
- changing expectations
- value for money in different elements of the care and support system.

Comment

39. Some of these issues are subject of comments in response to earlier questions. Hard data and modelling results would be very helpful, but it is worth noting that most of these factors are not completely independent variables. To varying degrees, they are functions of the overall local health, care, housing and support system, which can be adjusted to produce different outcomes by changes in decisions at key points and improved interaction between parts of the whole system. As examples, length of stay in residential care is in part a factor of premature entry, which as Henwood's report shows, can be affected by poorly managed hospital discharge processes and lack of effective information and advice services. Demand for formal care services can be strongly influenced both by levels of support for informal carers, and priorities of NHS hospital and community health services. Value for money in the care and support system cannot be seen in isolation from wider VFM considerations in health, housing and, in the case of disabled working age adults, training and employment.

Question 3: Given the problems 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.

40. The Commission's Call for Evidence explicitly acknowledges that a significant increase in resources will be required to cope with the predictable effects of demography and other causes of growth in demand. In particular, additional long-term investment is urgently required in:

- Home care, particularly with additional expertise in supporting people with dementia and other complex needs in their own homes, and including joint day and night-time nursing and care services
- Skilled, flexible professional support and back-up services for caring relatives, neighbours and volunteers, particularly older spouses/ partners, adult children providing substantial amounts of care to ageing parents and other relatives, and families of disabled younger people developing towards independent living
- Funding for diverse forms of self-directed support to enable the most cost-effective mixes of formal services, community capacity, and the individual's and family's own resources
- Workforce and management development and reorientation programmes to equip staff for the very different requirements of future working, in a context of personalisation, individual commissioning, service transformation, multi-professional collaboration and advances in technological applications.

41. For working-age disabled adults, including those with learning disabilities and mental health problems, responding to their support and care requirements should be part of a dynamic, integrated, cross-agency strategy for enabling them to maximise their citizen status and presence in the community, access training and employment opportunities, tackle long-term poverty, improve their health, living standards and quality of life, and acquire housing equity through shared ownership and other schemes. It is unacceptable and discriminatory simply to assume that, because of disability, people are not to expect to enjoy the same entitlements, rights and responsibilities as the non-disabled majority.

42. For people above retirement age, there are strategic issues to address about the funding of the system overall.

- Given the known demographic growth over the next 20 years, what proportion of the care and support bill is it reasonable to expect the state to meet? Are any international comparisons helpful?
- Viewing NHS, social care and public health provision as parts of an integrated system of prevention, treatment, care and support, what levels of NHS and public health resource should flow to the adult social care sector to fund step-up and step-down provision, prevent hospital admission and speed up appropriate return to the community, enhance quality and improve cost-benefit in the use of resources, and produce the right blend of professional health and social care expertise?
- Are there better, more creative ways of using the available capital and equity to establish a more productive framework of care and support? Private sector proprietors, both corporate and individual, have substantial volumes of their own capital invested in residential and nursing home care property. Social landlords, mostly housing associations, receive and borrow against another significant flow of public funding, and provide relatively small amounts of extra-care housing as part of their overall housing portfolio. Older people are said to own in the region of £1 trillion of housing equity, and those who enter residential care are obliged either to liquidate their capital or accept a charge on it in order to fund their care and accommodation. An integrated analysis of the capital framework might suggest better, fairer, ways to release and deploy capital from different sources to fund care and support.

43. A strategic question coming out of this analysis is whether the current systems of care and support provision and funding are broken and need comprehensively replacing; or whether there is sufficient room to improve and strengthen the system to make it fit for purpose and capable of handling the demands of the next 10-15 years. Introducing a wholly new system could have significant drawbacks: if insurance-based, it would almost certainly require an element of compulsion on potential users to participate; incentivising the insurance industry to cover the full spectrum of risk-groups could be expensive; and a scheme based on universal contributions to support the 25–35 per cent who would benefit may produce perverse incentives without necessarily increasing perceived fairness.

44. The present means-tested system clearly relates individual benefits to contributions, and discourages unnecessary or unduly early entry into the system. Areas for improvement could include:

- Reviewing the charging systems for both residential and domiciliary care to tackle the starker elements of perceived unfairness – this might involve higher capital thresholds, more tapered cost-sharing between the individual and the state, reducing the more extreme local differences in domiciliary care charges;
- Incentives to encourage the finance industry to provide, and individuals and relatives to use, more beneficial, economical and efficient schemes for releasing housing equity to contribute to care costs, whilst protecting a fair proportion of capital assets;
- Promoting and mainstreaming innovative formats for self-directed support, tailored to what older people and their carers and relatives find acceptable, to promote more flexible, co-produced models for care and support which integrate formal, informal and personal resources;
- Inter-agency frameworks, developed and supervised by local Health and Wellbeing Boards, to deliver more integrated, flexible and efficient deployment of resources and funding streams to support disabled working age adults and older people;
- Initiatives to develop and integrate outcomes-based approaches and productivity improvements, giving individuals and families a broader choice of routes to achieve and fund identified outcomes.

45. SCIE would be happy to supply the Commission with any further material it would find helpful.

SCIE
28 January 2011