DEMOS

THE CARE COMMITMENT

A NEW MODEL OF SOCIAL CARE FOR ENGLAND

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FEBRUARY 2021

This project is supported by the County Councils Network

Published by Demos February 2021.

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ACKNOWLEDGEMENTS

This report grew out of a letter I sent in response to Matt Hancock's call in March 2020 for suggestions for reform of the social care system. I am grateful to Polly Mackenzie, Ben Glover and the team at Demos for their offer to work with me to develop and publish my suggestions, and to apply the Polis research methodology to understand what the public think about social care.

My sincere thanks to the County Councils Network for their support for this project and the conversations they facilitated with county leaders. Stewart Young of Cumbria Council, in particular, gave helpful advice on the value of abolishing domiciliary care charges.

Most of all, I am grateful to Wiltshire County Council's leadership - Philip Whitehead, the Leader of the Council, Simon Jacobs and Laura Mayes, the current and former Cabinet Members for Adult Social Care - for their advice and for their vision, which I share, of a more community-based model of care in our county.

A range of other organisations supporting adults with care needs in Wiltshire have contributed to my thinking and commented on drafts of this paper. My thanks to: Geraldine Bentley (Centre for Independent Living Wiltshire), Babs Harris (Alzheimer's Support Wiltshire), Simon Billingham (Age UK Wiltshire), Judy Walker (Carer Support Wiltshire), and Suzanne Wigmore (Wiltshire Citizens Advice). My thanks also to Alex Fox (Shared Lives Plus) and Patrick Hall (ESRC Sustainable Care Programme).

I also gratefully acknowledge the help of the House of Commons Library with data on social care. My thanks also to Imogen Sinclair for her assistance with research, and to Dominic Llewellyn and Paul Riley of Outcomes UK for their work on the costing model which appears in the Appendix.

FOREWORD

The impact of the first truly global modern pandemic has ensured 2020 will be remembered as one of the most extraordinary years in history. The profound social and economic effects of COVID-19 will continue to be felt long after the immediate health concerns have been brought under control. That is why policy makers must begin thinking about the future right now.

For England though, no single issue has been exposed as more important for Government to tackle than adult social care. Even before the coronavirus emergency, local authorities, including the county authorities in the County Councils Network (CCN) which I chair, have been warning of the problems building up in a sector that is too often overlooked and underfunded.

The pandemic has ruthlessly exposed the deficiencies in the system and brought them to national public attention. This decade, it will no longer be politically expedient, or possible, to prevaricate over adult social care reform: the approach of successive governments of all political hues for over 20 years. Going forward, it is imperative that the adult social care sector is afforded the same priority and value as health to ensure that all those who are vulnerable are equally protected and able to thrive.

This is not simply about money. CCN has long argued that investment is needed, yes, but it will only be useful in the context of wholesale reform – reform that recognises factors such as agency; community; place; and that local partnerships between councils, providers and the NHS are just as vital as cold hard cash. To achieve such reform, we will need innovative ideas being put forward by influential thinkers. It will need politicians from all sides who are committed to these ideas to seek the consensus required to make positive change a reality.

That is why I am delighted that CCN have been able to support this project from Demos, exploring an enhanced adult social care offer which is properly funded and firmly rooted in local communities. Most importantly, its recommendations acknowledge that a reformed system can only achieve this if local authorities remain at its heart, with councils retaining their commissioning and system leadership role.

This report, authored by Danny Kruger, contains exactly the sort of bold thinking required to move the debate on this vital issue forward. Danny, a county MP, understands the challenges which our member authorities presently face in delivering across large geographic areas with both urban and rural communities, and the critical role that councils must play within a reformed and better funded system.

In addition to backing the role of councils and considering in detail one of the many ways a new system could be funded, the report contains fascinating insights into the views of the English public, shedding light on what they expect from adult social care reform. These perspectives will be vital in helping shape policy which is in tune with public opinion in the wake of the pandemic.

In contrast to the challenges that have so tragically beset our social care system in 2020, it is CCN's hope that 2021 will be the year in which England resolves how it will address its social care crisis. This report must play an integral part in making that case.

David Williams
Chair – County Councils Network

INTRODUCTION

The report proposes a new model of social care funding and delivery which I call 'the care commitment'. Part 1 of the report, written by me, outlines this model. It does not seek to replace, but to build upon the foundations of our current system: a mixed economy of national, local and private funding, with a mix of private, charitable and statutory providers. But it seeks to shift the support that government gives for social care towards families and communities; to generate more funding and more public confidence in the funding system; and to give professional careworkers the recognition and remuneration they deserve.

Part 2, written by the Demos team, summarises the evidence gathered from Polis. As this research shows, there is a model of social care that could command support across the British population, balancing the sense people have that good social care is personal (the responsibility of the individual and their family) and egalitarian (the responsibility of the state and wider society). Reconciling this tension is our mission.

The model we need reflects the great change that is underway across society: a growing focus on social and environmental concerns; a recognition of the value of home, family and neighbourhood; a retreat from the purely material questions of economic growth and individual wealth. This change is, in my view, consistent with the traditional conservative concern with personal responsibility. The individual has obligations to his or her family and community, just as families and communities have obligations to those individuals among them, who are vulnerable or in need of care.

This mutual obligation of individuals and society, with the family at its heart, underlies the principal objective of the system we need. Government should guarantee, first, that the family home will not have to be sold to pay for social care; and second, that all domiciliary care (i.e. care provided in the family home) will be free.

This will not be cheap. As I set out below, social care has been underfunded for decades. This is partly because of politicians' reluctance to subsidise so-called 'deadweight' cost, i.e. the fact that increases in public funding will partly go to cover fees formerly paid by individuals and their families. We need to grasp this nettle, for only by accepting a deadweight cost can we help transform the model of care in England. The current model incentivises families to seek residential care, which is publicly funded for those without assets and is more expensive than 'domiciliary' care provided at home. The experience of Scotland, which offers free personal care at home, is that the effect of shifting domiciliary care spending to the public sector is to help families keep their elderly relatives at home for longer, and so reduce demand for expensive publicly-funded residential care. As the Appendix states, 'free domiciliary care would pay for itself if it delayed entry into residential care by four months'.

This is one of the likely dynamic effects of a model designed to support family and community care. Without these dynamic effects, preliminary calculations suggest my proposal would cost the taxpayer an additional £6bn per year (of which deadweight is estimated at £1.4bn). This is a very large sum, and yet even if the dynamic effects did not happen it would, in my opinion, be a justified expenditure. We have underfunded social care for too long.

There is every reason to be hopeful that, as we emerge from the long shadow of Covid-19, we can build a system that gives elderly people (and other adults with care needs) dignity and independence, preserves family assets, and properly rewards care workers for their vital, skilled and loving work.

Even without the appalling strain on our care system inflicted by Covid-19, demographic concerns and fiscal realities made reform imperative. This reform must be for the long term. This is why the Government has committed to working across Parliament to find a solution that will survive general election cycles, to design a social care system fit for our time and the times to come. This report is a contribution to that process.

Danny Kruger MP

PART 1
THE CARE COMMITMENT

THE NEED FOR A NEW START

At the height of the first wave of the coronavirus pandemic, on 15 April 2020, Matt Hancock appeared at the despatch box of the House of Commons with a badge in his lapel bearing the word 'CARE'. This was in place of his customary 'NHS' badge, which he had received on his appointment from his predecessor Jeremy Hunt.

The monopoly of political and public attention enjoyed by the NHS was already coming to an end. In 2018, Mr Hunt had changed the name of his office to Secretary of State for Health 'and Social Care'. But with his new badge, Mr Hancock was saying that, at long last, social care was seen in government as equal in status and significance to healthcare.

The reason was obvious. During the pandemic, care homes and care workers have faced pressure comparable only to those faced by hospitals and NHS staff. This pressure has perhaps not been as intense as on Covid and Intensive Care wards, but it has been longer lasting and - given the relationships between care home staff and their residents, and the plight of residents' families denied meaningful access to loved ones for months last year - arguably more traumatic.

As the Polis research shows, the pandemic has brought public attention to the sad condition of social care in England. That condition has been most simply expressed as a lack of money: the 'presenting problem' for social care, as medics say, is its poverty. But this is, I think, the wrong way to conceptualize the challenge and the opportunity of social care. The problem goes deeper than money, and if we only think about its costs we will miss a more important truth.

The deeper problem, which lies beneath the underfunding of the social care system, is that as a society we do not really respect elderly people, or working age adults with care needs. Nor do we properly value the people who, paid or unpaid, look after them. This is why social care has always been the Cinderella of the public services, with underinvestment by successive governments largely accepted by voters. We have built a model that pushes people with care needs, carers and care workers to the margins of our society - out of sight, out of mind, and out of pocket.

We need to do things differently - for the sake of the people who need care, and for society overall. Getting the care system right will strengthen families, communities and the country as a whole, improving wellbeing and prosperity for all.

The system we need has three aims. It should *reduce demand* for care by incentivising healthier lifestyles, helping people access less formal 'upstream' care at home and in the community, and ensuring the care that people receive itself enables good health and wellbeing (and where appropriate, independence) for as long as possible.

The system should *grow the supply* of care by increasing public funding as part of a better and fairer system of finance; mobilising more people to take up caring roles, whether formal or informal, paid or unpaid; and increasing the provision of health-giving, purposeful activity for people in receipt of care.

And the system should *improve the delivery of care* by allowing more flexibility and better incentives in the funding regime, upgrading the regulation and remuneration of care workers, and reforming the regulation of care homes.

These three aims are mutually reinforcing, and distinctions between supply and demand sides, or the formal and informal parts of the economy of care, can be unhelpful. We need to bring together the different parts of this economy in an integrated and holistic system that treats carers, and those they care for, with respect.

To this end, I propose a new framework for care in England: the 'Care Commitment', namely a signed pledge by government, the local authority and the family of the person with care needs that they will each fulfil their respective responsibilities toward that person's care. For government, the commitment is to guarantee a generous funding package for all, regardless of assets, income or contributions. For the local authority, the commitment is to provide whatever further funding is necessary, above what the individual can afford to contribute themselves. And for the family, their commitment is to do whatever is reasonably within their power to support their relative, including looking after them at home for as long as this is practical and in their relative's best interests.

The Care Commitment is, in one sense, a statement of the obvious. We have many elements of a good care system already, and of course many, many people are working selflessly, whether paid or unpaid, to support elderly and working-age adults.

And yet sometimes the obvious needs stating. Government and councils represent, respectively, the nation and the local community. These are the associations that, with the family, give each of us identity, opportunity and safety. Nation, community and family each have a role to play when we are vulnerable or in need. The nation can provide a universal, equitable entitlement and a framework of legal regulation. The community can provide a sensitive, discretionary service, adapted to the needs and circumstances of the individual and the supply of care locally. And the family can provide unstinting, unconditional, loving care and, where appropriate, decision-making responsibility on behalf of their relative. The Care Commitment is a formal recognition of these roles, which together provide the foundations on which a better system can be built.

Our broken model

Currently, the sum total of the UK's public system of social care consists of the obligation to fund care for people who fall below the means test, some benefit entitlements for carers, and the work of the Care Quality Commission to regulate the provision of paid-for care. Local authorities fund social care for people without sufficient assets and expect families to organise this care, providing unpaid care or paying for professional support if they fall above the means test.

This hands-off approach is, in principle, a good thing: it means we have a lot of family responsibility, and a diverse care market to cater to the range of customers, whether funded by the council or privately.

The system is clearly broken, however. The means test is too brutal, with many families facing enormous strain looking after their loved ones at home with inadequate support, and others facing catastrophically high costs for privately-funded care. And on the supply side, the diverse market of providers includes some operators performing very poorly, often due to serious difficulties in recuiting and retaining staff.

As Professor Martin Green of Care England has said, care should be about 'giving people a life', whereas too often it is solely about meeting their immediate physical care needs.[1] A new care model must reward 'relational' care that respects the dignity and emphasises the quality of life of the person receiving care.

The principles of the system we need are set out admirably in the Care Act 2014, which puts a 'general duty' on local authorities to 'promote individual wellbeing', including 'personal dignity', 'participation in work' where appropriate, 'family and personal relationships', and 'the individual's contribution to society.' It insists that councils respect individuals' wishes and act to reduce or prevent the development of care needs, rather than simply managing them.

The imperative now, in the shadow of the tragedy of Covid-19, is to fulfil the aspirations of the Care Act by redesigning the system that funds and delivers social care. The need for a redesign is due partly to the success of modern medicine and partly, paradoxically, to the increasing ill-health in which we live.

The society we are becoming - with longer lives but also the risk of entrenched ill-health and complex comorbidities in the population - desperately needs models of care that both encourage healthy lifestyles and look after us as we age.

We are fortunate that more and more younger people, who in former times would have died because of their health conditions, are now able to live a proper span of years. The challenge is that they live with disabilities that require expensive, or at least intensive, care and support over many decades.

1 House of Commons. Long-term funding of adult social care. First Joint Report of the Health and Social Care and Housing, Communities and Local Government Committees of Session 2017–19, 2018. Available at https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/768/768.pdf [accessed 11/02/2021]

It is therefore important to distinguish between models of care appropriate to people, particularly in later life, whose need is for what we might call embedded relationships - to belong to a safe, supportive and settled community, whether in their own home or a residential setting; and those, generally younger, for whom care should be about enabling independence and a life lived as much as possible in regular society, including (where possible) in work.

The system we need is necessarily very complex and diverse, catering to people with a vast range of different needs. These include many more people with a far greater level of acuity or medical complexity than a generation or two ago.

Therefore, while we need to better support informal and family care, we also need a higher level of skills in social care; we need both more unpaid *and* more professional care, not less of one and more of the other. And despite the natural preference for family-based care and support, there are a growing number of people with care needs who do not have the option of unpaid care - for instance, elderly people without children, or without children nearby. We need to develop a system that provides them with the warm and relational support that others receive from their families.

Start with families

Matt Hancock's adoption of a 'CARE' lapel badge (like his 'NHS' one) raised the prospect that he might be about to take up the suggestion, from the Labour Party and others, of a new 'National Care Service' - a single, taxpayer-funded system of social care managed by the Department in Whitehall (or by a new quango like NHS England). This would, I believe, be very bad news - and I was relieved to get a ministerial assurance in the House of Commons that no such step was contemplated.[2] Indeed, rather than the social care sector needing to be more like the NHS, the health service has much to learn from social care.

Across a wide range of health conditions and particularly in terms of public health, we need a more social and less medical model of care. This entails a greater focus on prevention; more treatment in community settings rather than in large, remote hospitals; and more recognition of the role of non-medical treatments overall.

I have suggested that the individual's family, the community and the nation each plays a vital and distinct role in the care economy. This is not to overlook the role of individuals themselves, especially those of working age or older people who value their independence. As the Care Act specifies, individuals need to have their own voices heard, not just through their families. Indeed, it is essential to recognise the extent to which health is the responsibility of the individual. Before he or she is a passive 'patient', receiving treatment decided by a doctor, he or she is a free agent. Much of the responsibility for preventing ill health rests with personal choice and lifestyle. In many cases, the primary cause of illness is not genetics or accident, but decisions made by the patient.

This responsibility is heavily conditioned, however, by external circumstances, opportunities and environments. For all that health is a personal responsibility, the reality is that we are well or ill in our relationships. The 'strengths-based' approach to health and care, which seeks to build on the assets a person has rather than simply treating their symptoms of need, considers the person's wishes, interests and capabilities, but also their social setting - who they live with, and what the wider community offers in terms of activity and support.

Policy should seek to improve the conditions which affect people's decision-making, by reinforcing the natural strengths of families and communities. In this regard, the NHS struggles to do what social care does naturally and by necessity: works with family members, friends and neighbours to ensure the individual gets the support he or she needs. In many cases, family members, friends and neighbours *are* the social care system, providing unpaid care for someone in need because they have to, want to, and no-one else will.

There is a more general consideration here. We tend to define social care as the provision of physical, sub-medical care. In fact a much wider set of needs determines people's wellness or independence, including financial resilience, isolation or loneliness, and mental health. While there need to be professional or statutory interventions aimed at meeting these needs, the best way to prevent them becoming critical - and the best way to ensure an individual does not develop conventional social care needs - is to strengthen the family and community support available to them.

Carers UK estimates that 12 per cent of the UK population are informal carers and provide care to almost 8 million people. It is suggested that the financial value of the informal social care provided by friends and family to elderly and vulnerable adults is almost £140 billion per year. This is roughly 20% more than all spending on healthcare. It is 10 times the amount the government spends on adult social care. As this suggests, social care offers immense value for money.

2 Kruger, D. OPQ: Health and Social Care - 6 October, 2020. Danny Kruger.org.uk, 2020. Available at https://www.dannykruger.org.uk/news/opq-health-and-social-care-6-october-2020 [accessed 11/02/2021]

In arguing against the takeover of social care by the NHS, or the establishment of a parallel National Care Service, I am not proposing a system in which health and social care operate independently. As the coronavirus crisis has shown, and as everyone working in both sectors knew already, health and social care are essential to each other. One purpose of retaining and enhancing the organic, pluralistic model of social care is to reduce demand on the NHS, helping people avoid GP visits or hospital stays by ensuring they get the help they need at home and in the community.

As the Polis research confirms, while people recognise the need for acute healthcare, they also want a less medical, more relational approach overall. But the financial and regulatory system pushes activity towards the acute end of care. This applies within social care as well as between the NHS and social care. Care workers who provide professional support in people's homes and in care homes (the 'acute' end of the sector) are poorly-paid and frequently overworked. There are structural or supply-side reasons for this, which I address below. But there is also rising demand for paid-for social care, and this is partly the consequence of overspill from unpaid care. Put simply, many people are living in residential care who could have - as they and their families wished - stayed at home if the funding system enabled this.

To reduce pressure on paid-for care services and on the NHS, we urgently need to improve the experience of the five million people across the UK providing care for their loved ones at home. Here, at the most 'social' end of the health and care spectrum, is where our thinking about reform should begin. Changes here will affect the entire health and care economy. The famous 'funding gap' in social care, usually estimated at upwards of £1.5 billion, presumes current trends of demand continue. It is certainly likely that the call on the public purse will continue to grow, and government should be prepared to finance a widening of access and extension of provision. But it is not inevitable that the additional money must all be spent on care for people with high needs, usually in residential settings.

If more money were available to improve the experience of both patients and carers at home, with more daycare, respite care, and overall flexibility with budgets to commission what is right for the individual and their family, we could see a shift in the balance of care, and budgets, away from residential towards domiciliary and community care.

Families are the richest resource in the social care economy, but this wealth is not financial, and it needs some finance in order to be activated. A little investment in carers would leverage multiples of its own value in averted costs further along the health and social care spectrum.

Full-time carers are currently entitled to Carers Allowance, worth £67.25 a week, though it is notable that a third of eligible people do not claim this benefit. This suggests that the system is too opaque or bureaucratic, though there may also be significant deadweight costs in a system that provides money to everyone who is eligible for it.

Financial support for unpaid carers should not be made in isolation from the budgets that are spent on paid-for care and support. We currently have different systems, administered by different departments in Whitehall, for supporting unpaid carers and commissioning paid-for care. Predictably, this is a complex process that leaves many people bewildered. These budgets should be combined and managed by the adults they are spent on, or instead by their families or advocates.

Moreover, if we recognise that care starts with unpaid carers, not professional careworkers, it should be possible for people in need of care, with appropriate safeguards, to use some of the money currently used to commission agency staff to pay friends and family for their time spent providing care. This idea was proposed by two select committees in 2018, and it remains a simple, not uncontroversial, but in my view, vital change to restore the 'social' in social care.[3]

It may be argued that the effect of supporting and therefore increasing unpaid care will be to drive women out of the workforce and back into the domestic sphere. This is to mischaracterise the world of work in the 21st century. Human beings are increasingly being edged out of manual and clerical jobs by automation and globalisation. What remains as uniquely human responsibilities are the functions of creativity - all the activities of innovation, exploration and artistic endeavour - and of care - looking after each other, whether as children or adults with care needs. Choosing to do this for one's own dependent, rather than being paid to do it for a stranger, is increasingly a preferred option for many people; it should not be assumed that the only valid career for a man or woman is a paid role far from home.

3 House of Commons. Long-term funding of adult social care. First Joint Report of the Health and Social Care and Housing, Communities and Local Government Committees of Session 2017–19, 2018. Available at https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/768/768.pdf [accessed 11/02/2021]

Indeed, the opportunity and, I believe, the desire is growing for a new and better economy for all, in which adults of either sex are enabled to work closer to home or from home, with a mix of family and community responsibilities as well as paid work in the wider economy. Employers are increasingly aware that offering greater flexibility for workers with care responsibilities can help retain good staff. A greater focus on family life, as part of a general adaption of our economic and social model, will ultimately lead to greater equality of the sexes.

The Care Commitment

I set out below the outline of a new funding model based on social insurance, to cover both residential and community-based care. As now, this includes a means test. The big question is whether the family home should be included in the means test, as it currently is in the case of residential care, but not in the case of community-based care.

My proposal is that the family home should not be included, and that all domiciliary care costs for older people should be covered from public (that is, National Insurance) funds. These guarantees should be made on one condition: a commitment by the individual's family to play their part too.

Polis research shows that the public appears to support the Government's promise that no-one should have to sell their family home to pay for their care. This policy is plainly intended to ensure that people have paid a mortgage for many years to own a family home should not be penalised by the arbitrary event of, for instance, dementia. It would, however, be wrong for a family to pass the responsibility of caring for their elderly relative to the taxpayer, in order to inherit a valuable asset.

There is a danger that the exemption of the family home from the mean test will further erode the responsibilities of families.

The condition I propose adding to the manifesto commitment is that an individual's home should be exempt from the means test, and all domiciliary care costs for older people be met for free, so long as they and their family sign a 'Care Commitment'. For the individual, the Care Commitment is a statement of the sort of care they want and need, and a declaration of intent to live in a way that will support their own health and wellbeing. It thus asserts the rights and responsibilities of the individual, who is and must be at the centre of all discussions and decisions about the care they receive.

For the family, the Care Commitment is a pledge that they will help support their relative as much as they can. This includes a reasonable undertaking to look after their relative at home for as long as this is in their interests and practical for the family; to help their relative access services, support and social opportunities in the community as desired and appropriate; and to engage meaningfully in the care of their relative if they go to live in a home.

The Care Commitment would also be signed by a representative of the Local Authority, confirming the responsibility the council has towards the person in need of care, and by any provider involved in supporting the person, whether at home, in the community or in a residential home. It includes an obligation on the part of the council and care providers to consult respectfully and meaningfully with the family members or friends who have signed the Commitment. In some circumstances, it may be possible or appropriate for employers (of the adult with care needs or their carer) to sign the Care Commitment too, undertaking to allow reasonable flexible working for their staff member.

Finally, the Care Commitment would be signed by the Secretary of State for Health and Social Care as the custodian of the National Insurance Fund and the Care Quality Commission, confirming the national commitment to the funding and regulation of the care system.

The Care Commitment would have no legal force but would, I hope, have some moral force. It is intended as a nudge to help people do the right thing by reminding them of the expectations that society has of families. Most people, if the support they received from the council and the community were sufficient, would wish to look after their elderly parents at home for as long as possible. The Care Commitment reflects this natural instinct and sends a clear signal that society respects people who fulfil their responsibilities. In Japan, people earn tax breaks if they move to live near their parents. The British version of this is the protection of the family home from being sold to pay the care bill, so long as the family undertakes to play their part as well.

FUNDING

Social insurance

In 2019/20, 575,000 people were in receipt of long-term community-based care (i.e. they still lived in their own homes) in England, costing local councils a total of £6.9 billion. 264,000 people were living in residential care homes or nursing homes with their places funded by councils, at a total cost of £7.2 billion. With other elements of expenditure added in, including short term support, total gross expenditure on adult social care services was £19.6 billion. Once

income from clients' fees, grants and other sources was accounted for, net expenditure on adult social care in England was £16.7 billion in 2019/20.[4]

In addition, the NHS also provides some social care services to those with significant health-related care needs. NHS England spent around £4.5 billion per annum on Continuing Healthcare (CHC) services.[5]

Although estimates of informal carers are often described as 'unpaid carers', some of these individuals may be in receipt of benefits associated with their provision of care. In 2019/20, a total of £2.9 billion was spent on Carer's Allowance in England and Wales.[6]

The public expenditure described here is almost certainly not enough. As mentioned, many experts suggest a shortfall of around £1.5bn. This may not be enough either, but it is important to recognise that such projections are on the basis of the current, unreformed system. A different model of social care would introduce all sorts of dynamic effects which made cost predictions difficult.

Nevertheless, there is a strong case to be made for significantly increasing the funding of social care, and this is usually seen as a case for more taxation.

As councils are gradually permitted to retain more of their Business Rates revenue, with a proportionate reduction in central government grants, they will become more dependent on their own resources for funding social care. But the 'inverse care law' (the poorest areas with the smallest tax base and the least health and social care services have the highest care needs) represents a serious challenge to this model. We risk a growing volume of demand for social care dependent on a shrinking volume of supply. The inverse care law means that local taxes are inappropriate sources of revenue for social care. These taxes should be used for other local priorities.

General taxation, even if it were collected nationally and allocated fairly, is inappropriate for social care, because it breaks the link between the payment for and receipt of services. This link is valuable because social care, arguably unlike purely medical treatment, involves significant personal and social factors: personal preferences for different models of care, and the family and social context in which the individual lives, should be central to decisions on the type of care that is provided.

It is right for wider society to help people with the costs of care, especially those without wealth of their own. It is also important that government ensures everyone has the right sort of help with essential needs like washing and dressing, which they might not wish to receive from family and friends. But the business of providing an elderly person with a home, and company, and help with the ordinary business of life, are not the responsibility of government, but of families and of communities. Government can and should help with the financial aspects of this responsibility, but it should not assume the whole burden itself when there is a family which could take its share of the weight. Government is there to help families do their job, not to do their job for them.

This principle is reflected in the Polis research into public opinion. While there is strong public support for the principle that government should contribute to social care costs, very few people think government should pay for it all. Indeed, we know from the success of local fundraising that communities see social care as, in part, a local social responsibility. And it is evident that people regard self-pay and insurance as a necessary element in the care economy.

Therefore, I do not propose we move towards the Nordic model of fully-universal, comprehensive social care paid for by the taxpayer. A preferable system, and as Polis shows, one that is more popular with the public, is the social insurance model which operates in different ways in countries including Germany and Japan.

The case for social insurance is in the balance we need to strike between two contradictory facts. On the one hand is the fact that lifestyle and personal circumstances - including your wealth and the capacity of your family and community to look after you - are and should be relevant factors in the care you need and receive. On the other hand is the fact that, lifestyle notwithstanding, the need for social care can fall arbitrarily, with some people incurring enormous costs and some none at all. Social care imposes both personal and egalitarian obligations. Social insurance helps reconcile this contradiction by what Churchill famously called 'the magic of averages', which enables both a personal and an egalitarian element to the system.

Social insurance entails a compulsory payment into an insurance fund which provides a level of cover for all citizens. It is, like a tax, compulsory, but it differs from ordinary tax-funded services in two respects: it is ring-fenced, with the income from payments allocated solely for social care not general spending;

4 NHS Digital. Adult Social Care Activity and Finance Report, England - 2019-20, 2020. Available at https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20 [accessed 11/02/2021]

5 UK Parliament. Question for Department of Health and Social Care UIN 4739, 2020. Available at https://questions-statements.parliament.uk/written-questions/detail/2020-01-17/4739 [accessed 11/02/2021]

6 DWP. Benefit expenditure and caseload tables 2020. HM Government, 2020. Available at https://www.gov.uk/government/publications/benefit-expenditure-and-caseload-tables-2020 [accessed 11/02/2021]

and it is personalised, or 'contributory', with one's entitlement to social care funding determined in part by one's history of contributions.

The compulsion is needed because the free market cannot provide insurance cover for social care due to the adverse selection effect: the old and ill would seek the cover more than the young and healthy, making the system unaffordable. A social insurance system requires the young and healthy to pay in too, subsidising the people who need care until they themselves do.

Social insurance is how healthcare was funded from 1911, when Churchill and Lloyd George introduced the 'stamp' for sickness and unemployment benefits, until 1947, when the NHS took over healthcare. In those days, of course, all social care was entirely informal or, for the wealthy, self-funded in the form of paid nurses. But in those days most people did not live, as most people do now, well past their 60s and often with long-term conditions.

National Insurance was created to cover healthcare and unemployment benefits. It has become just a part of general taxation, rather than a genuinely contributory fund. NI generates around £140bn a year. This is roughly equivalent, as it happens, to the combined health and social care budget.

We should make NI 'real' for social care, by dedicating a portion of the NI fund to this purpose. As outlined below, people's contributions over time should entitle them to a pot of money for their future care costs.

The pillar of funding

The current system of social care entails a complex array of financial entitlements - for community-based care (e.g. day centres), for home improvements, for domiciliary care, for residential and nursery care, and benefits for carers - which are all funded and accessed in different ways. When it comes to residential care, people with assets over £23,250 are expected to fund their places in full, and then on a sliding scale until the point where they have assets of only £14,250, when the local authority steps in to cover the whole cost. Assets are not assessed for entitlements to community-based care.

The funding model we need consolidates the multitude of entitlements available for different aspects of social care into a single budget, composed of different elements. To this end, I propose a simpler structure, a 'pillar' of funding that applies to both working age and older people, and is available to pay for all types of care, whether community-based, domiciliary or residential.[7] This pillar consists of three layers: a 'basic element' funded from NI; a 'contributory/self-pay element' funded from NI, from individuals' own resources or those of the local authority; and an 'excess costs element' funded by the Local Authority.

At the base of the pillar is the basic element, the first tranche of funding that is used for the individual's social care needs. This represents a guaranteed quantum of money that is available for that person's personal care needs over the course of their life. It grows with interest, but is depleted by every withdrawal.

The value of the basic element will depend on actuarial work, but my suggestion is that it should start (before capital growth) at around £30,000. On the basis of current expenditure, this is broadly equivalent to seven years of community-based care (including domiciliary care) at average costs, or a single year of residential or nursing care. Averaged across both community-based and residential care, £30,000 would buy three years of care. On current rates, this would cover the full costs of care for most older people, and would allow the NI fund to guarantee all domiciliary care costs for older people would be covered for free.

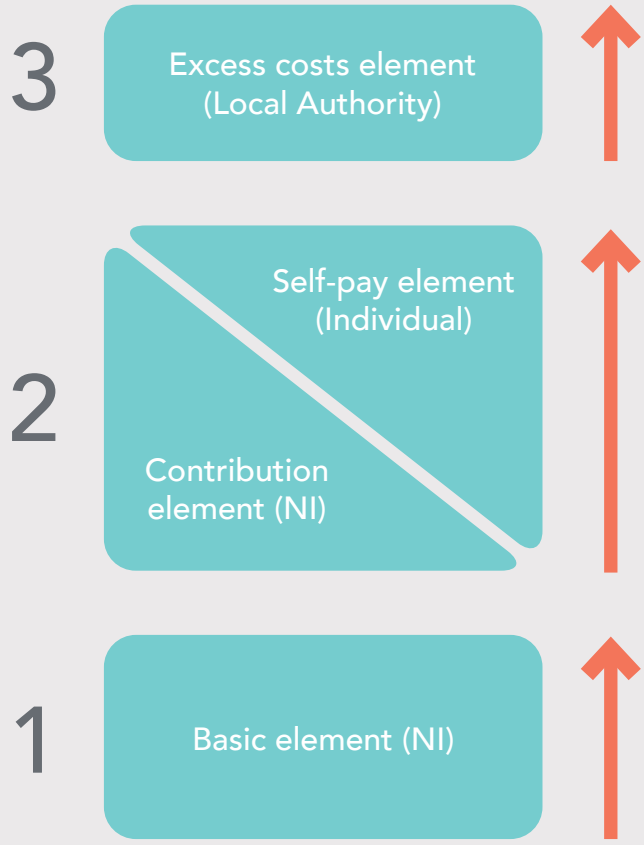
For the minority of people (whether working-age adults in community-based and residential settings or older people in residential care) whose care costs exceed the basic element, the contribution/self-pay element is used. If the individual has made NI contributions, these are drawn down first. Once this funding is used up, if they fall above a means test threshold of £15,000 in available assets (the family home is excluded by virtue of the Care Commitment), they are required to self-pay up to a total lifetime cap of £100,000. Those without assets of £15,000 have the self-pay element, up to the same cap, funded by their Local Authority.

For people with costs that exceed the basic element and the capped contribution/self-pay elements, the Local Authority covers all further social care needs.

The funding model outlined here is intended to create a single system for both working age and older adults. The only distinction is the lifetime guarantee of free domiciliary care as part of the basic element for older people; working age adults would receive a maximum of £30,000 for their care, whether in a community or residential setting, before the contributory or self-pay element kicks in. Because they generally have higher care costs, have fewer assets for self-payment, and have not built up a substantial NI pot to pay the contributory element, working age adults will therefore remain largely reliant on local authority resources. It is important in calculating funding for the elements of the pillar that councils are not underfunded for this vital work.

7 The funding is available for personal care only. 'Housekeeping' costs for domiciliary care and 'hotel' costs for residential care are not covered.

THE SOCIAL CARE FUNDING PILLAR



Uncapped. Costs that exceed the basic and contribution/self-pay elements are funded from councils' own resources.

Funding for those whose costs exceed the basic element, capped at £100k. The contribution element is calculated on the basis of the individual's National Insurance contributions over time. The self-pay element applies once the contribution element is used up. It is based on a means test, excluding the family home where families have made the Care Commitment, with an asset floor of £15k. Individuals without assets over £15k have their self-pay element funded by the LA.

£30k available for everyone who has care needs, at home or in residential care, drawn down over time. Funded from National Insurance. This entitlement funds personal care only (i.e. excludes 'housekeeping' costs in domiciliary care and 'hotel' costs in residential care).

Commissioning care

If the 'funding pillar' helps simplify the money available for an adult with care needs, and clarifies the various financial responsibilities of individuals, councils and the National Insurance fund, the next question is how this money is to be used. Who controls it, and where - i.e. on which services or providers - can it be spent?

The starting assumption is that the individual, or their family when they cannot make fully informed decisions themselves, manages the budget available from the social care funding pillar. The Care Commitment should set out expectations and processes here, in line with the future of commissioning. The Care Commitment should also require individuals and carers to consult professionals before making decisions. This creates the opportunity for social services to work proactively to design services that work for different groups of people in need of care. Councils are able to secure good deals through block-purchasing, and the best care is not always arranged as part of an individual care package. Contracts could be strengthened to incentivise preventative support.

On the other hand, individuals and families may wish to receive a cash grant rather than a commissioned service, as happens under the current Direct Payment system. Currently, only 40% of working age adults and 20% of older people use this option.

In Germany, by contrast, 75% of people in receipt of help from the social care funds take the cash option rather than make use of formal services.[8] Most take the cash rather than in-kind benefits, even though the cash option is less generous, because it enables families to supplement the care they can provide themselves with flexible support, whether informal or professional, sourced from within the community.

This principle is central. While we certainly need more skilled professionals, properly regulated and properly remunerated, we also need more care delivered by family, friends and neighbours.

8 House of Commons. Long-term funding of adult social care. First Joint Report of the Health and Social Care and Housing, Communities and Local Government Committees of Session 2017–19, 2018. Available at https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/768/768.pdf [accessed 11/2/2021]

According to Polis, public opinion appears divided on this proposal, but in my view, individuals should be free to use their social care funding to compensate their family for their time and devotion, or to make it possible for a neighbour to give time helping them with odd jobs. This flexibility will prompt a new market to appear of carers, subject to some regulation but mostly regulated (as childminders are currently) by the attentive concern of the individuals who receive care, and their families.

FIXING THE STRUCTURES

A new staffing strategy

The symbiosis of health and social care means that changes of policy in one area affect the other. Through the NHS People Plan, the Government has taken steps to improve the pay and career progression of health workers. The result is a shortage of staff for work in the care sector, a problem exacerbated, in the short term at least, by Brexit.

The National Living Wage has also added nearly £500m to care costs, a bigger sum than the impact of demographic pressure.[9]

Matching pay increases in the NHS would cost an additional £4.1bn.[10] However, there are other advantages to working in care than pay, including job satisfaction and - potentially at least - greater flexibility.

For despite these pressures, there is a great pool of available care in our communities. For instance, the Tribe Project has developed a 'micro-commissioning' service, using artificial intelligence to enable public services to find new volunteers, upskill them, and allow for those seeking care to find local support. For instance, when the pandemic hit, North Yorkshire County Council (NYCC) used Tribe to coordinate a large-scale volunteer effort, finding 279 council staff unable to perform their usual duties to volunteer. Tribe has helped NYCC to support over 1000 vulnerable individuals across the county.[11] Given 56% of domiciliary care workers are currently on zero hours contracts, Tribe presents an attractive flexible working proposition where those providing support set their own hourly rates.[12]

Many people would be appreciative of the opportunity for work that is flexible and fulfilling. AI-enabled systems could find many more local carers, including those who have other unpaid caring responsibilities and could complement this with paid care work in their local community.

As this suggests, we need to recognise the spectrum of caring roles and support the flexible combining of provision. At the moment, we only have two forms of carer: an informal carer, usually a relative, untrained and unpaid though eligible for some additional benefits; and a professional care worker, fully trained, working for a nationally regulated care home or agency and with all clients assigned to their caseload. We need to do more for both categories, and we need to define a new category between these two options.

As outlined above, informal carers need more support, including the right to be paid using cash grants from the individual's social care budget. Professional care workers need better regulation, including registration as part of a national workforce.

We must create models of care that sit in between the informal and formal care economy. Alongside these two categories, we need a third: the 'semi-professional carer', a capable and responsible local person, with basic training, who is paid to look after clients at his/her own discretion.

Crucially, informal carers should be able to call on flexible semi-professional care when in need of respite. This would prevent the patient having to move from care by the family at home to professional residential care, simply for want of some more help at home.

Reform the care home sector

A great strength of the care home sector in the UK is its diversity and independence. We do not have a system of large state-run care homes. Only 4% of England's 12,000 care homes are owned by the NHS or local councils. 83% are owned by private companies and 13% by charitable trusts. In all, there are around 6,000 operators, suggesting an average of two homes per company, and the great majority single-home businesses.

But with diversity comes a high variation in quality.

9 House of Commons. Long-term funding of adult social care. First Joint Report of the Health and Social Care and Housing, Communities and Local Government Committees of Session 2017–19, 2018. Available at https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/768/768.pdf [accessed 11/2/2021]

10 Gershlick, B. et al. Health and social care funding: Priorities for the next government. The Health Foundation, 2019. Available at https://www.health.org.uk/sites/default/files/2019-11/GE03-Health%20and%20social%20care%20funding%20-%20long%20read.pdf [accessed 11/02/2021]

11 Tribe Project. Case Studies, 2021. Available at https://tribeproject.org/cases/ [accessed 11/02/2021]

12 Fenton, W. et al. The state of the adult social care sector and workforce in England. Skills For Care, 2020. Available at https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2020.pdf [accessed 11/02/2021]

Before the pandemic struck, Independent Age found that the quality of care homes had worsened in the last year in more than a third of local authorities.[13]

Public funding for care home places does not fully cover the costs of running a care home.

This is partly deliberate: councils are only required to pay the operating costs, not to fund capital improvements. The result is that small operators struggle to stay afloat, and cannot borrow without demonstrating an ability to attract sufficient self-funders to cover the shortfall. This means that a home in need of renovation is likely to close, or is forced to sell out to a large operator which can make the necessary investment.

Our care home system, then, can only function when it is dominated by large companies who can achieve economies of scale on borrowing costs and capital expenditure. They also drive down staff wages.

Three reforms are needed. First, we need to get more money into the system. Boosting informal and semi-professional care will free up resources in local authority budgets to pay proper prices for care home places. This should be used to reward informal carers and to invest more in domestic and residential care. Additional funding for residential care should seek to cover the full costs of a care place, including money for capital investment.

Second, we need to support small private care homes, including those operating as non-profit social enterprises. It should be easier for small care home companies, perhaps with only one or two homes, to borrow to invest, and government should enforce a more rigorous competition policy to prevent consolidation. There should be an explicit purpose to preserve or create a plural supply-side in the care home market.

Third, we need to stimulate a better model of care, building on examples set by public health experts such as Atul Gawande. In his book, 'Being Mortal', Gawande promotes models which treat the recipient as an agent in his or her own care. This means avoiding premature dependence and instead enabling people to retain responsibilities, which can extend from continuing to work, to volunteering, to caring for a pet or plant.

When we lose our independence, we don't suddenly become entirely dependent. Indeed, we are all to some extent interdependent on our network of relationships throughout our whole life. We need a conception of good care that emphasises the dignity, relationships and agency of the individual, rather than simply their physical needs.

There are a number of innovative schemes and initiatives cropping up in response to this gap in provision across the private and social sector.

This is the principle behind Buurtzorg, a Dutch care company which deliberately does without complex management hierarchies and works with residents and families to manage budgets collectively. Where appropriate this can include alternative models of supporting adults with care needs, including 'shared lives' models which place individuals with families in the community rather than in specialist homes. These and other innovations, which actually hark back to a more traditional model of community-based care, should be enabled. I am pleased that my local authority, Wiltshire County Council, is actively developing plans for a Buurtzorg-style model for adult social care.

For example, Shared Lives recognises that many people in need of care have a mixture of personal and complex needs and therefore require the right mix of formal and informal care. Shared Lives matches people with a carer who offers support in their own homes, balancing family and community life. A single role could combine unpaid and paid elements and the carer is part of a UK-wide support network which offers training. Social Finance reported that, compared to other forms of regulated care for people with learning disabilities, Shared Lives costs £26,000 less per year.[14]

Others have sought to expand the middle ground between the two extremes of independent living and care homes. In 'Planning For Retirement', the County Councils Network (CCN) urges government to consider boosting the provision of 'Retirement Communities' which combine high quality housing options with tailored support services, allowing residents to maintain privacy, access communal facilities and care and support as necessary.[15] Among other things, CCN recommends designating a new planning class in order to reflect the potential of such developments for local communities.

13 Independent Age. Care homes getting worse in one in three local councils – urgent action needed to end inadequate standards of care, says older people's charity, 2019. Available at https://www.independentage.org/news-media/press-releases/care-homes-getting-worse-one-three-local-councils-urgent-action-needed-to [accessed 11/02/2021]

14 Social Finance. Investing in Shared Lives, 2013. Social Finance. Available at https://www.socialfinance.org.uk/sites/default/files/publications/sf_shared_lives_final.pdf [accessed 11/02/2021]

15 County Councils Network. Planning for Retirement: How Retirement Communities can help meet the needs of our ageing population, 2020. Available at https://www.countycouncilsnetwork.org.uk/wp-content/uploads/dlm_uploads/ARCO_CCN-Report_DIGITAL_version-2.pdf [accessed 11/02/2021]

PART 2
WHAT DO THE PUBLIC THINK?

AN INTRODUCTION TO POLIS

Demos has pioneered the use of Polis, a tool which allows respondents to interact with each other constructively: mapping out the lay of the land with regard to opinion on a given subject, identifying attributes that define and differentiate between different clusters of opinion, and crucially highlighting areas of consensus between otherwise disparate attitudinal groups.

In particular, Demos is the first organisation anywhere to conduct Polis using a nationally representative sample. This innovation provides a uniquely rich view of public attitudes around a given subject, enabling a grounded theory study with citizens providing their verbatim views and able to react to views they would not otherwise be exposed to, at a scale where nationally and demographically representative inferences can be drawn from the results.

Demos recruited over 1,000 respondents from England for this study. Responses were weighted to be representative by gender, age, region and social grade.

Cluster analysis - demographics

Polis conducts an automated cluster analysis of results, allowing us to explore how attitudes tend to hang together across the population. The number of clusters depends on the results, and is not predetermined - in this case, two clear groups of opinion emerged.

Group A comprises just under three quarters of those allocated a group (74%). They tend to be slightly older; they are more prevalent outside of the South East and London; more likely to be female; more likely to be retired; and more likely to have had personal experience of social care.

In contrast, Group B tend to be slightly younger, and skew towards the South East and London. They are more likely to be in work and to be male; they are less likely to have had experience of social care.

Group A	Group B
Roughly three quarters of the population	Roughly a quarter of the population
More likely to have had interaction with social care	Less likely to have had interaction with social care
More likely to be female	More likely to be male
Skew older	Skew younger
More likely to be retired	More likely to be in work
Less prevalent in London and the South East	More prevalent in London and the South East

Cluster analysis - attitudinal differences

We can also examine how attitudes differ between the groups, with some of the major differences in opinion highlighted in the table below.

Group A	Group B
Think people in their community would like to provide care for others	Don't think people in their community would like to provide care for others
Willing to pay higher taxes to ensure no one must sell their home to pay for care	Unwilling to pay higher taxes to ensure no one must sell their home to pay for care
Support higher taxes to provide more support for informal carers	Opposed to higher taxes to provide more support for informal carers
Support the introduction of ten days of paid 'carer's leave'	Opposed to the introduction of ten days of paid 'carer's leave'
Support greater autonomy for those with personal budgets	Opposed to greater autonomy for those with personal budgets

MAIN FINDINGS

The need for change

We found a very strong consensus across both groups on the need to reform the social care sector in this country and agreement that it should be a priority for the government. A clear majority of both groups support the statement: "Improving social care should be a high priority" (statement submitted by participant), suggesting there is strong support for government proposing changes to the social care system in England.

Likewise, a clear majority of both groups believe that "dignified social care is long overdue in the UK" (statement submitted by participant) and that "the quality of care for older and disabled people needs to greatly improve". This suggests that the public believe the UK's current social care settlement fails to provide dignity to those that need it and that it must improve.

We also found strong support for the notion that the Covid-19 pandemic has made these concerns more pressing, shining a light on the deficiencies in our current social care system. Very strong majorities in Group A and at least a plurality of Group B support the statements: "Covid has highlighted how vulnerable and older people who require social care are ill-treated and marginalised" (statement submitted by participant) and that "the pandemic has shown we need to change the way we care for older and disabled people in this country".

Care expectations

Similarly, we found a strong consensus on the public's expectations for any new social care settlement. This is useful when considering what principles should guide social care reform.

First, we found a clear consensus across both groups for everyone getting the care they need, even if we can't afford to pay for it out of our own pockets. A clear majority across both groups supported the statement: "no one should go without the care they need in illness, disability or old age, even if they are not able to pay for it themselves". Second, we found a similarly strong consensus that social care should provide more than the basics, even if we cannot afford to pay for it ourselves. A clear majority across both groups supported the statement: "everyone has the right to care that is more than just washing, dressing and feeding but allows them to live a life, even if they are not able to pay for it themselves."

Central vs Local and the role of communities and councils

We explored who the public would like to have responsible for the delivery of adult social care. We found evidence that there is greater public support for a locally-led rather than centrally-led service; the former was supported by 8% more respondents than the latter, and this preference holds across both groups (though was smaller in Group B than Group A).

Furthermore, we found a consensus across both groups on the need for a more community-based approach in our support for older and disabled people. Clear majorities - some 94% of Group A - supported the participant-submitted statement: "we

need to have a more community minded attitude towards supporting vulnerable people". However, there was much greater division when considering whether people think others in their local community would like to care for others. A majority of Group A supported the statement: "I think people in my local community would like to provide care for others", with only just over a quarter supporting it in Group B.

Eligibility and funding

A majority of respondents across both groups believe that, while government should help with the costs of care, individuals or families should be expected to contribute something. Similarly, we found a fairly strong majority of support in Group A and just shy of majority support in Group B for the wealthy having to pay more, with 61% of Group A and 49% of Group B supporting the statement: "Some aspects of social care should be means-tested, e.g., those with substantial savings should contribute to the cost of their care".

In further evidence that the public wants individuals to contribute something for social care, we found fairly weak support and indeed division across both groups for the notion that social care should be entirely funded through taxation. Less than half of Group A felt that social care should be paid for entirely through tax and that no one should have to contribute, with just a quarter of Group B supporting this statement.

Perhaps unsurprisingly, both groups strongly supported the statement: "no one should be forced to sell their home for care". However, we found much less consensus on the trade-offs potentially needed to deliver this. Indeed, the public were highly divided on whether they would support paying more tax to avoid anyone having to sell their home to pay for care; 76% of Group A supported this statement, with just 26% of Group B supporting it.

Indeed, any statements that proposed tax changes, even if in exchange for something respondents deemed positive, were highly divisive. On the contrary, requiring the public to pay into an insurance fund was much less so. 70% of Group A and 45% of Group B supported the statement: "Everyone, including the young and healthy, should have to pay into an insurance fund to provide some social care cover for all citizens if they need it in the future". This suggests that social care reformers may wish to harness the framing and language of an insurance fund to build public support for this change.

The role of families

As we have seen above, we found a consensus across both groups that individuals and families should contribute something towards the costs of social care. We also found a fairly strong consensus of support for greater incentives for families to care for loved ones. 90% of Group A and 52% of Group B back the statement: "There should be greater financial or work related incentives for families to care for loved ones needing support".

While this suggests the public back a bigger role for families in meeting the demand for care, we did not find support for the notion that families or communities should be responsible for the vast majority of caregiving. Just 28% of Group A and 38% of Group B supported the statement: "Providing care to elderly or disabled people should mostly be the responsibility of families and communities, not the government".

However, it is important to flag that this negative reaction is likely due to the strongly worded nature of the statement - that the duties of care should *mostly* be the responsibility of families and communities - and it does not suggest the public do not wish to see a bigger role for families; we have seen above that the public back schemes to incentivise more family caregiving. Instead, it tells us that any new social care settlement should strike an appropriate balance between family and community-based care with state-provided care, likely with more family and community care than today, but not wholly reliant on this.

Informal carers

It is also useful to consider how the public thinks our treatment of Britain's millions of informal (unpaid) carers should change.

We found a very high level of support in Group A and plurality support in Group B for greater flexible working patterns for informal carers, with incentives for this provided by the government. We also found similar levels of support - high in Group A, close to a majority in Group B - for the notion that informal carers should play a bigger role in meeting our country's social care needs.

However, we found fairly high levels of division when it came to more specific changes that might benefit informal carers. A full 77% of Group A supported the statement: "To make it easier for people to balance informal care with work, all employees should have the right to ten days of paid carer's leave per year", with just 34% of Group B in support. We saw even higher levels of division when considering whether

the public would be willing to pay higher levels of tax to offer more generous financial support to informal carers, with just a quarter of Group B backing these statements, as opposed to extremely high support from Group A.

Personalisation

Recent years have seen moves towards greater personalisation in the care system and the use of personal budgets, which give those receiving care greater discretion over who should provide care to them. However, our Polis finds that the public are divided on how to take this agenda forward.

More than half of Group A supported the statement: "People who receive funding from the government to pay for their own personal care should be able to spend it in any way they see fit", compared with just 21% of Group B in support. In addition, we found a very clear divide in attitudes regarding whether those needing care should be able to use government funds to pay for friends or family members to look after them. A significant 73% of Group A supported this statement, with just 38% of Group B in support: a very stark divide.

A better rewarded, more professional and regulated formal care sector

Clear majorities in both groups support carers receiving higher pay and better working conditions. 97% of Group A and 55% of Group B supported the statement: "the government should recognise the services of care workers and improve their working conditions and pay".

Building on this, we found a very high level of consensus for giving carers the opportunity to gain qualifications and unlock higher pay. We also saw strong support for higher care standards and better regulation of the formal care sector. Both groups were united in their support for formal carers to be able to spend more time with their clients and for agency workers to be more tightly regulated.

APPENDIX 1: CALCULATING THE COST OF THE PROPOSAL

The report proposes a social insurance approach to funding adult and older people social care. The introduction of the proposed social care funding pillar model that underpins the social insurance approach detailed in the report will have several impacts on the nature and level of public funding for social care. The following provides a high-level initial assessment of these potential impacts, with figures adjusted to 2019/20 values where possible, and based on current need assessment levels.

Working age vs older people 65+

Overall local authority-funded social care expenditure is broadly evenly split between Working Age vs Older People 65+, though the nature of the respective spends varies reflecting the different profiles of need.[16] Joint Health Foundation / The King's Fund studies[17] identify that the majority of people aged 18–64 who need care do not have significant assets or savings, so qualify for publicly funded care under the current system. This would largely remain the case with the proposed social care funding pillar model. Changes have therefore been modelled only for people aged 65 and over, and therefore affect only half of local authority-funded social care expenditure. However, it is noted that under the proposed model some funding responsibility would move from the local authority to the social insurance approach for working age people.

The impact of the social care funding pillar will also depend upon whether DWP expenditure such as Attendance Allowance and Carer Allowance are included within the pillar funding. These total £7.2b p.a.[18]

Lifetime guarantee of free domiciliary care for older people

To move from the current situation of a mixed economy of means-tested local authority funded, self-pay and NHS-funded continuing healthcare to a lifetime guarantee of free domiciliary care for people aged 65+ will result in both the current self-pay element largely transferring to the public sector, and increased demand.

The UKHCA[19] estimate the value of self-funded domiciliary care in England to be £0.7b p.a. and therefore this would be the level of increase in public funding to meet the guarantee for those already in receipt of self-funded domiciliary care. There would also be some element related to 'tariff income' i.e., the contributions currently made by social care recipients and their families as either means-tested

16 House of Lords. Social care funding: time to end a national scandal. Economic Affairs Committee, 2019. Available at https://publications.parliament.uk/pa/ld201719/ldselect/ldeconaf/392/392.pdf [accessed 22/02/2021]
17 Watt, T. et al. Social care funding options: How much and where from? The Health Foundation, 2018. Available at https://reader.health.org.uk/social-care-funding-options [accessed 22/02/2021]
18 HM Government. Benefit expenditure and caseload tables 2019. Department for Work and Pensions, 2019. Available at https://www.gov.uk/government/publications/benefit-expenditure-and-caseload-tables-2019 [accessed 22/02/2021]
19 UKHCA. An overview of the UK homecare market. 2019. Available at https://www.ukhca.co.uk/downloads.aspx?ID=611#bk1 [accessed 22/02/2021]

contributions or top-up above the rate the local authority are prepared to pay. However, it has not been possible in this brief study to untangle the domiciliary care versus residential care elements of the over £3.1b p.a.[20] this amounts to. With the majority of the cost likely to be related to care home fees it has been considered under that cost modelling.

Scotland's experience when introducing free personal care (FPC) was an increase in identified need and take-up which The King's Fund (TKF)[21] has calculated to result in a 37% increase in the provision of domiciliary care if a similar approach was introduced in England. TKF estimate the cost of the additional demand to be £1.8b p.a.[22]

In addition, the current public sector average hourly rate for domiciliary care of £17.48[23] is likely to increase due to the providers being less able to cross-subsidise public and private funded clients. It is estimated that self-pay rates are on average 10-15% more than local authority-funded rates. This gap is unlikely to be fully closed but with an anticipated increase in demand, shortage of workforce and high turnover of providers in the sector due to low margins this is anticipated to create strong pressures for a significant increase. Based upon the current proportion of self-funders and current difference between public and private funded client charge rates, it is anticipated that around the UKHCA proposed minimum price for homecare rate of £18.93[24] may need to be paid. This would result in a potential further cost pressure of £0.2b p.a.

In summary, the introduction of the lifetime guarantee of free domiciliary care for older people is anticipated to cost an additional £2.7b p.a.

However, review of Scotland's experience shows that one of the outcomes of FPC is an increased duration an individual is able to live in their own home and how quickly they can return to and remain in their home following hospital admissions with the following changes noted: (1) the number of "occupied geriatric long stay beds" decreased by 39% between the period 2003 and 2008; (2) The number of "long stay residents aged 65+ supported in care homes" decreased by 4% between 2002/3 and 2009/10; and (3) the number of "NHS delayed discharges within the six week discharge planning period" decreased by 93.2 % between January, 2001 and October, 2010.[25] These were all in the context of an increasing 65+ population.

A 4% reduction in the number of older people requiring care home placements in England would result in cost saving of £0.1b p.a. The substitute domiciliary care costs are already included in the estimate of increased demand, of which this is part, and this is a net saving.

21% of Delayed Transfer of Care (DTOC) days in England in 2019/20 were due to awaiting care package in own home. The cost of this to the NHS of this is estimated to be £30m.[26]

Basic entitlement:

The report proposes a basic entitlement under the social care funding pillar of £30k per person for all future care recipients (the system would not apply to current recipients). The impact of lifetime guarantee of free domiciliary care for older people has already been considered and so only the impact of residential care expenditure is considered here. The assumption is that the basic entitlement is on a similar basis to Scotland i.e., it covers personal care costs only and does not include hotel costs. Personal care costs are typically a third of the total provider fee with hotel costs being the balance.[27]

Up to the first £30k of residential care currently being funded by self-payers aged 65+ would become an additional publicly-funded social care cost. Based upon TKF figures[28] this would equate to an on-going cost of £0.7b p.a., assuming a 40% rate of churn of residents per annum.[29] This suggests the basic entitlement would need to be phased in as

20 NHS Digital. Adult Social Care Activity and Finance Report, England - 2019-20. 2020. Available at https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20 [accessed 22/02/2021]
21 Watt, T. et al. Social care funding options: How much and where from? The Health Foundation, 2018. Available at https://reader.health.org.uk/social-care-funding-options [accessed 22/02/2021]
22 Ibid.
23 NHS Digital. Adult Social Care Activity and Finance Report, England - 2019-20. 2020. Available at https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20 [accessed 22/02/2021]
24 UKHCA. An overview of the UK homecare market. 2019. Available at https://www.ukhca.co.uk/downloads.aspx?ID=611#bk1 [accessed 22/02/2021]
25 Bell, D., Rutherford, A. and Wright, R. Free Personal Care for Older People: A Wider Perspective on Its Costs. Strathprints, 2013. Available at https://strathprints.strath.ac.uk/46778/ [accessed 22/02/2021]
26 NHS. Delayed Transfers of Care. 2020. Available at https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/ [accessed 22/02/2021]
27 Bushnell, J. Free personal care: Insights from Scotland. Independent Age, 2020. Available at https://www.independentage.org/policy-and-research/FPC/Scotland-briefing [accessed 22/02/2021]
28 Watt, T. et al. Social care funding options: How much and where from? The Health Foundation, 2018. Available at https://reader.health.org.uk/social-care-funding-options [accessed 22/02/2021]
29 Fernandez, J. and Forder, J. Impact of changes in length of stay on the demand for residential care services in England: Estimates from a dynamic microsimulation model. Bupa Care Services, 201. Available at http://eprints.lse.ac.uk/33896/1/dp2771.pdf [accessed 22/02/2021]

people start to require care rather than simultaneous introduction for all current social care recipients.

The impact on contributions from social care recipients and their families, which amount to over £3.0b p.a.,[30] is difficult to establish at this stage. The introduction of the basic entitlement is expected to remove 'tariff income' contributions for residential care, resulting in this element moving to public funding. It is anticipated that both the basic entitlement and means tested contributions will work to a cap on personal care and total care home rates that will be paid through public funds and therefore top-up funding is expected to continue and to remain privately funded. For the purposes of these calculations a 50% split between public and private funding of the current client contribution amount has been assumed.

The Competition and Markets Authority[31] found that average local authority fees for residential care of older people are below the full cost of providing care and, to compensate, self-funders are charged 41% more by care homes. In the event of the public sector potentially funding up to the first £30k of care home fees, this is likely to create system pressure to reduce the gap between local authority and self-funder fee rates, depending upon the dynamics with top-up fees. It is difficult to anticipate the level and timeframe of such an increase, but even a 3-percentage point reduction in the gap would increase public expenditure by £0.1b.

In summary, the base entitlement is anticipated to increase public funding of residential care for older people by £0.7b p.a., and may result in a further £1.5b p.a. cost to cover the potential of client contribution 'tariff income' becoming paid through public funds.

Self-pay element:

The self-pay element applies once the contribution element is used up. It is based on a means test, excluding the family home where families have made the Care Commitment, with an asset floor of £15k. For the purposes of these calculations the self-pay element will relate solely to the funding of residential care for older people aged 65+.

The means test will apply when an individual enters residential care in relation to the hotel costs as the basic entitlement is only for personal care. The means test will also apply when the personal care costs funded by the basic entitlement are exhausted.

The impact will be to increase public expenditure on social care as the current means test includes property and is based upon an upper asset threshold of £23,250 and lower threshold of £14,250 i.e., virtually all property owners would not qualify for local authority funding of their residential care. The initial additional costs will be the funding of home owners with less than £15k of financial assets who require residential care and under the current system would be self-paying.

It is estimated that 10% of the 65+ population would meet the criteria of home owner with less than £15k assets.[32] If this is extrapolated to the residential care population in England this would equate to 23% of the self-funders in residential care which equals 39,000 people who currently self-pay who would become publicly-funded.[33] On an on-going basis this equates to an additional public cost of £1.0b p.a. through a combination of initially funding hotel costs and then the full cost to an agreed maximum rate. This amount would not kick in until after the basic entitlement is exhausted.

It would then mean going forward that 23% of current residential care self-funders would be publicly funded in their first 6 months through the basic entitlement (on the basis that most people entering residential care would be expected to have consumed half of their basic entitlement already) and then a similar 23% continue to be funded due to being within the asset floor. This leaves 34% of people in residential care self-funding versus the previous level of 44%.[34]

Excess cost element:

Where the combined NI contribution and self-pay elements reach a total of £100k, it is proposed that the excess costs will be funded by local authorities. Due to the basic entitlement this equates to when the total cost of care has reached £130k.

30 NHS Digital. Adult Social Care Activity and Finance Report, England - 2019-20. 2020. Available at https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20 [accessed 22/02/2021]
31 CMA. Care homes market study: Final report. 2017. Available at https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a-750b82533a/care-homes-market-study-final-report.pdf [accessed 22/02/2021]
32 ONS. Total wealth in Great Britain: April 2016 to March 2018. 2019. Available at https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/incomeandwealth/bulletins/totalwealthingreatbritain/april2016tomarch2018#total-household-wealth-by-age-of-household-reference-person-hrp [accessed 22/02/2021]
33 NHS Digital. Adult Social Care Activity and Finance Report, England - 2019-20. 2020. Available at https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20 [accessed 22/02/2021]
34 Ibid.

In 2011 the Dilnot Commission[35] estimated that at age 65, 1 in 10 people – typically those who spend several years in a care home – would face 'catastrophic' care costs of more than £100,000. Adjusting care costs to 2019/20 levels, the current comparison would be 'catastrophic' care costs of more than £130k.[36] This therefore indicates 1 in 10 people at age 65 are likely to exceed the proposed cap. The excess cost local authorities would fund under the proposed model is estimated to be £42m p.a.

The method for calculating this assumes a similar ratio would apply to the mix of people in residential care, with 10% exceeding the proposed cap and with 24% (see above) continuing to be self-funders under the new model. This equates to 2.4% who would eventually become funded by the local authority i.e. 9000 people. However, a proportion of these would become funded by the local authority in any event where the value of the person's assets had diminished to the upper threshold. These would be people with a combined asset base of less than £153,000 (£23,250 upper limit and £130k cap). From ONS wealth data for 2018 the proportion that would have had more wealth than this but would now qualify for local authority funding due to the cap equates to 73% of the 9000 people i.e. 7000. The average length in residential care would come into effect to cap this amount with the LSE research[37] showing an average of 2.5 years in residential care and only 25% reaching the 3 years the £100k cap would typically fund, and only 20% reaching at least 4 years. Consequently, the local authority would only additionally fund 20% of the 7000 of people i.e. 1400. The annual cost for this cohort is estimated to be £42m.

Social care funding pillar	Core Increased Public Costs (p.a)
Free domiciliary care for older people	
Value of current self-funded domiciliary care	£0.7b
Cost of the additional demand	£1.8b
Hourly rate pressure	£0.2b
Basic entitlement	
Value of current self-funded care home fees	£0.7b
Residential care rate pressure	£0.1b
Potential effect on 'Tariff fees' and 'top-ups'	£1.5b
Self-pay element	
Impact of £15k asset floor and excl. property	£1.0b
Excess cost element	
Impact of £100k cap and means test	£0.04b
Total	
	£6.0b

Summary

The changes resulting from the proposed social insurance approach been modelled only for people aged 65 and over, and therefore affect only half of local authority-funded social care expenditure. It is noted that under the proposed model some funding responsibility would move from the local authority to the social insurance approach for working age people. However, given the low income and assets of most working age people in receipt of social care, and their current reliance on public funding, the proposal is likely to be Treasury-neutral in respect of this group.

The calculations show increases in public funding in several areas, which are summarised in the table below. One factor that would have a positive impact on the balance of funding that has not been modelled at this stage is the shift in care mix the model would give, both in terms of family and informal care and domiciliary care increasing and the duration in residential care consequently reducing. To illustrate the potential effect, free domiciliary care would pay for itself if it delayed entry into residential care by four months.

35 Dilnot, A. Fairer Care Funding: Supporting Documents. 2011. Available at https://www.bl.uk/britishlibrary/~/media/bl/global/social-welfare/pdfs/non-secure/f/a/i/fairer-care-funding-supporting-documents.pdf [accessed 22/02/2021]
36 HM Government. GDP deflators at market prices, and money GDP March 2020 (Budget). 2020. Available at https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-march-2020-budget [accessed 22/02/2021]
37 CMA. Care homes market study: Final report. 2017. Available at https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a-750b82533a/care-homes-market-study-final-report.pdf [accessed 22/02/2021]

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PUBLISHED BY DEMOS FEBRUARY 2021.

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