Costs of caring for an ageing population

A Radical New Vision for Social Care.

The Socialist Health Association Cymru / Wales believes that any discussion of the costs of caring for an ageing population a sustainable way must look well beyond the present delivery model.

The key principles for any future system of long term care must include:

1. *Universal coverage* – The need for long-term care is part of the normal public sector services and should be treated just as health and education.

2. *Maximum risk-pooling* - The most efficient way of insuring ourselves against the costs of impairment or frailty is to all pool resources in order to cover that risk, as with the NHS.
3. *Equity* – The system should be equitable and should not discriminate against people because of condition, age or geography.
4. *Entitlement* – All citizens should benefit from the system and should not be disadvantaged by income or ability to pay. The system should be funded from general taxation and be free at the point of use, as with the NHS.
5. *Control* – All citizens should be able to get the right flexible support to meet their needs, to be able take the level of control that is right for them and their families.

The three key elements of the proposal are:

5. *Fund a universal system and end means-testing* – Social care on the same footing as healthcare, funded from general taxation, with resources distributed on the basis of need.
6. *Invest in citizenship and community* – Social care must offer support that people and families can shape to their circumstances, and that helps people contribute as citizens and strengthens family and community life.
7. *End privatisation and the complexity of the current system* – Social care must be integrated into one national system that invests resources locally and ends the wasteful procurement systems that currently undermine human rights.

Achieving these objectives will require an end of the failed policies of austerity and an acknowledgement of the crucial role of social solidarity, pooling of individual risk and service delivery through quality, accountable, public provision.

Welsh Government Challenge.

We recognise that the Welsh Government operates within resource constraints due to the UK austerity programme. In the decade to 2020 its budget will have been cut in real terms by 7% which means £1.2 billion less to spend on key public services. This places major constraints on what can be achieved in the short term but it must not place a barrier on the debate about what a humane, sustainable social care service should look like.

According to StatsWales, social services Welsh spending on the over 65 year age group has increased from £485 million in 2008-09 to £547m in 2015-16. This is obviously much better than the 8% real terms cutbacks in England over recent years (Institute for Fiscal Studies) However this good relative picture cannot disguise the urgent need for more investment in social care in Wales.

This investment is not only needed to address issues of the quantity of service need but also of quality and priorities. We need a clear view of what should be addressed first and what are the relative importance of other factors.

Meet current unmet need.

Between 2006-07 and 2015-16 the number of 65 years+ people receiving social services declined by about 15% (Stats Wales). However the 2016-17 return saw an annual increase of over 20% to 62,500 people (based on incomplete returns). But this report was compiled in line with the changed requirements of the Social Services and Well-being (Wales) Act 2014 so it is not possible to fully compare like with like. It therefore remains very likely that fewer people are receiving care despite the increased ageing of our population.

There is no strong evidence that fewer people are being referred to local authorities for assessment so it is likely that eligibility criteria and social care practices are being changed in line with budget availability with the result that fewer are actually getting publicly funded services.

The 2016-7 Stats Wales returns show that there were 70,303 assessments of need undertaken which led to the provision of 20,886 care and support plans i.e. just under 30% of those who asked for an assessment.

This figure again has to be understood in the context of the the Social Services and Well-being (Wales) Act 2014. This requires that once an assessment decides that a care and support package can meet a person's 'well-being outcomes' a further decision has to be made on whether these needs can be 'sufficiently met' by support coordinated by the clients themselves, their family or carer, or by community-based providers. Only if this is not the case will the local authority provide the service.

The new National Assessment and eligibility guidance will therefore mean that public provision will only be available to the most vulnerable of our citizens with the most difficult and complex needs. This increases the scope for many more potential beneficiaries to fall through the care net not least because they have neither the means or the support network to respond to the identified levels of need.

Meet growing need

Demographic changes and the ageing of our population will inevitably mean that need for social care will continue to grow. However anticipating how big and fast this growth will be

is difficult not least as the boundaries between health and social care are becoming increasingly blurred in people who suffer from conditions such as dementia or who are frail and vulnerable due to a range of multi-system disorders.

Conventional wisdom would have us believe that we have to manage a ticking demographic time-bomb. By 2041 the number of people age over 65 is expected to increase by almost 37% with the most dramatic increase is expected for people aged 85 and over – a 119% increase. This is against a backdrop of Wales already having a higher proportion of people aged over 85 than the rest of the UK (Social Care Wales National Assessment Report 2017). It has been suggested that this could lead to an increase of over 50% in the demand for domiciliary care services and over 60% increase in the need for residential care.

However people's greatest demand on health and social care is not strictly related to age itself. Instead services are most intensively used in the last few years of life whenever that takes place. And so when we take increased life expectancy into account then the need for services could become relatively less as the population gets older.

Dr Allyson Pollock has pointed out that despite an ageing population, demographic changes have so far accounted for a relatively small proportion of the increase in spending on health care in the UK. While overall spending (between 1965 and 1999) grew by 3.8 per cent a year in real terms, the demographic changes alone required annual real terms growth of just 0.5 per cent a year.

There will be some absolute increase in demand as the size of the older population increases but depending on the health and well-being of an older population it is possible that need may be less than the most pessimistic predictions would have us believe. But to achieve this desirable outcome we must invest in a healthy ageing strategy now.

The costs of an ageing population cannot only focus on expenditure in health and social care. We must, as both the Social Services and Well-Being (Wales) (SSWB)Act and the Well-being and Future Generations (Wales) (FGWB) Act 2015 require, include provision to promote prevention and early intervention so that as we live longer lives, older people will be healthier, happier and more independent. Here, the provision of adequate housing, including the role of different forms of sheltered housing, needs to be ensured.

Many of the services that will allow this to happen are not provided on a statutory basis by our public bodies and have been in the front line of the austerity cut-backs. The harsh reality of austerity means that the general statutory duties included in recent Welsh Government legislation are being ignored in the face of other priorities. Unless this is acknowledged and reversed we may find the demographic time-bomb becoming a reality.

Reduce barriers between health and social care.

The National Health Service Act was passed in 1946 and provided for a free, universal health service. In 1948 the National Assistance Act repealed legislation that extended back to Tudor times. It gave responsibilities to local councils to provide services, particularly residential, for older people and they were empowered to levy means tested charges. Over time these duties greatly expanded to include community care services but means testing remained unchanged.

The difference between a “free at the point of service” NHS and means / eligibility tested

social care is a massive practical and confusing barrier between the services that begins at Welsh Government level. Different national standards have developed in the two services and there are substantially different professional cultures. As well they are often competing for funding streams as resources are channelled separately to local health and local authority social care organisations. The challenge of creating integrated health and social care is therefore difficult, complex and begins at the very top of government. It goes much wider than removing organisational barriers as the experience in Northern Ireland shows.

These divisions have also led, at times, to the unedifying spectacle of two publicly funded public bodies slugging it out in expensive litigation to decide which of them should pay for the care for highly vulnerable citizens.

A vulnerable person may have a range of needs which do not readily fit into a social care or health / nursing care categorisation. Reflecting this ambiguity a small scale industry has emerged which is involved in arguing for fairly arbitrary care decisions which make no sense to the recipient. No matter how justified separating “health” and “welfare” might have seemed in 1948, it no longer makes sense if we wish to deliver integrated, humane care.

The SSWB Act has placed a duty on local authorities to collaborate with their relevant partners. But the same does not apply to the NHS. SHA Cymru therefore warmly welcomes the Welsh Government's plans to address this major omission as outlined in its white paper, “Services Fit for the Future”.

These statutory duties and responsibilities must be driven forward though a range of initiatives including the Regional Partnership Boards. These boards must continue to evolve and wield real power, under-pinned by statute, to bring health and social care together though joint planning and the creation of unified, needs-based budgets. The policy intention of integrated services must have delivery and governance structures in place to ensure that they become a reality for service users.

These initiatives must cascade down though health boards and local authorities to front-line delivery bodies such as primary care networks and primary care teams. Hopefully the recently announced substantial investment of £68m into health and care centres /hubs will provide important impetus and produce evidence of what works in the Welsh context. It is vital that these lessons are quickly mainstreamed into everyday core provision as the final report on the Parliamentary Review on Health and Social Care strongly urges.

The Welsh Government must set a clear statutory timetable in place for the full integration of the planning and delivery of health and care at a local level. We can look to the experience in Scotland to see what can be learned from their “integration joint boards” and from the plethora of, often regrettably fragmented, experimentation that is taking place in England. Structural re-design may be only one element of a programme for integration; changes in professional cultures and creating different means of “spanning” both organisational and professional boundaries is essential. Research arising from network theory may also be instructive.

SHA Cymru also welcomes the Welsh Government's commitment to joint complaint procedures and advocacy where over-lapping of health and care services take place. The continuing unedifying experience over “who pays” for certain elements of care should not continue to be perpetuated in a complaints process with endless semantic arguments over “who is responsible”. This denies services users or their families proper redress and

prevents valuable lessons being learned when things go wrong. It is also important that external service regulators and inspectors work in an integrated way to deliver coherent overviews on quality assurance from a user and citizens' point of view as outlined by "Services Fit for the Future".

Joint-working in Wales has grown apace since the launch of the Making the Connections agenda in 2006 as highlighted by a recent publication by the Welsh NHS Confederation (Health and Social Care - Celebrating Well-being: A selection of case study examples). Programmes such as the Integrated Care Fund have produced many excellent examples of what can be achieved including the reduction of delayed transfers from hospital care by almost one third in the last decade compared to the continuing increase in England (House of Common Library; Health and Social Care Integration 2017).

But it is important that integrated health and social care should not be seen just in terms of reducing the pressures on the expansive acute hospital sector. It must be firstly about delivering better outcomes for service users.

Social justice & social contract

Many people believe that social care is paid for through public agencies on a similar basis as the NHS and that their taxes and national insurance contributions go to achieve this (Citizens Advice Wales 2016). They are bitterly disappointed when they are confronted with the reality that social care is means tested. Andrew Dilnot described the means testing of social care as "the most pernicious means-test in the whole of the British welfare state".

Most of the people who require expensive social care have worked hard to save, paid their taxes and social insurance and hoped to leave a legacy to their future generations only to find that their care needs swallows up what they have saved.

There is evidence that many people who would have to pay for a service either refuse a financial assessment (and so get no service) or do not take up the service when they are aware of its cost and what is involved. Dame June Clarke states, in her 2017 Jack Jones Lecture, that many are not prepared to go through this complicated and demeaning process of "baring their all to a stranger" whose interest, at times, is best served by denying their application.

In any year, on average, less than 10% of the over 65 yrs old population will be in receipt of social services. Within that group the scale of need is unpredictable at an individual level and over time. Based on English evidence it has been estimated that one in ten people could face social care bills in excess of £100,000 with a 70% loss of assets for those with a median income and assets if they require five years of residential care.(Dilnot 2011). While most who move to a residential or nursing home do not live for more than 1-2 years, about 20% survive for three years and more (Older Peoples' Commissioner Literature Review 2014).

There is no reason to assume that Wales is substantially different. This cost of care is prohibitive for all but the super-rich.

Social solidarity based on pooled risk provision for the whole population therefore seems appropriate --- covering both the rich, the comfortably off and the poor --- for services being delivered on the basis of need. This service should not be paid for at the point of

need but through a more socially just, progressive taxation programme.

Priority between community and residential care.

There seems to be a consensus that virtually everyone would prefer care in their own homes and their own community rather than in a residential setting. SHA Cymru would not disagree with that. We are therefore surprised that there is little evidence from StatsWales of a significant increase in the number of "homecare" hours (12.5 million – 13.5 million) being provided through local authorities over the last decade or in the numbers of clients receiving home care (39.3000 in 2015-16; 46.800 2005-06). And over this time there was a 20% reduction in adults over 65 yrs supported in care homes. This again seems to show that financial pressures are taking precedence over meeting care needs and policy priorities.

We need funding mechanisms that avoid the perverse incentives that litter our present care system. Continuing NHS care is free while social care is means tested. In some instances domiciliary care will avoid more expensive residential care costs and people may stay inappropriately at home. In other cases, if residential care costs are more easily paid for, there may be less enthusiasm to support service users staying in their own homes and in the community.

SHA Cymru has concerns that the balance between community and residential care is not always driven by service users' wishes or needs but is dictated by financial pressures. Generally community care is thought to be a less costly option and consequently residential care places are being lost in response to austerity. It is therefore essential that the statutory needs assessments that are now required accurately reflect the relative balance between community and residential care and that this informs future service planning in a transparent and honest way.

Staff recruitment, retention and training.

Too much of social care is delivered by under-valued, under-paid and under-trained staff. Quality of care has its own premium and we must, as a caring society, be willing to pay for it. Future funding must acknowledge the need for this quality premium.

Unison, the public sector trade union, has been highlighting this problem for many years. Its 2012 survey found that 79.1% of home care / domiciliary workers reported that their work schedule is arranged in such a way that they either have to rush their work or leave a client early to get to their next visit on time. 56% of workers received between the then national minimum wage of £6.08 an hour and £8 an hour and 57.8% were not paid for their travelling time between visits. A key part of the Unison's response to this survey was to call for an Ethical Care Charter which would include the end the practice of the "15 minute visit" which undermines both the dignity of care recipients and care workers. When the University of Greenwich undertook an evaluation of the charter at the end of 2016, only one local authority in Wales had signed up to it.

In the Labour Party's UK General Election Manifesto in June 2017 it acknowledged this need and pledged to provide an addition £1billion of funding in its first year in power to support the implementation of the Ethical Care Charter.

A Resolution Foundation study (2013) found that the care worker sector in the UK was one that has low levels of formal qualifications --- 37% of adult direct care workers hold no

qualifications and 61 % only hold Level 2 qualifications or below. It felt that this reflected the fact that historically care has been provided informally by women within the family and, as such, remains low-status. Eighty four per cent of domiciliary care workers are women and many are motivated by job satisfaction and the emotional rewards of care work rather than financial gain.

The Welsh Government had indicated its wish to see domiciliary care workers being registered with Social Care Wales by 2020. Such registration will improve the standing and status of care workers but there will be an inevitable resource implication as the registration programme proceeds. In view of the progress to date the 2020 registration target still seems very ambitious.

Public sector austerity is imposing downward pressure on the fees paid to care homes and providers which is compromising their capacity to achieve a dignified quality provision. This is compounding a staffing crisis as this low paid sector finds itself even less attractive compared to other potential employers in a growing low wage economy. Not only is difficult to recruit staff there is also a high level of staff turnover due to the poor employment practices, long irregular hours, poor career structure, absent training as well as casual and zero-hours contracts. An end to the public sector pay cap must be the first step towards ending this totally unsatisfactory and unstable situation.

The Older Persons' Commissioner has also pointed out that problems exist in retaining quality managers and nursing staff. There is a discrepancy between the nursing standards in the NHS and in the care home sector. This can be due to a number of factors, including limited clinical supervision, a lack of peer support in nursing homes and a lack of opportunities for professional development.

And as the first report of the Parliamentary Review on Health and Social Care in Wales pointed out, a hard Brexit could make the situation worse for the sector that is heavily dependent of a migrant workforce.

Public / private mix

For decades more and more social care has been provided by the “for profit” sector. In the domiciliary care sector the proportion provided by the independent private providers has increased from just over 50% to over 80% in the last decade and it also provided 78% of residential care places (StatsWales). Much of this shift was driven by a combination of ideological dogma that “private is good, public is bad” and by so-called value for money assumptions that cheaper private sector provision is preferable to the “wasteful” “poor value for money” and “expensive” public sector.

The “for profit” sector is a combination of smaller individual providers and ever bigger corporate bodies. Their “better value” is largely at the expense of their work force's wages, terms of service and training as well as the fees that it charge its residents.

In its submission to the National Assembly's Health, Social Care and Sport Committee's investigation of the health and social care workforce Unison pointed out ...“ it is clear the marketisation of social care has failed.... Care services need to be delivered directly by the local authority. The terms and conditions of social care workers employed directly by a local authority are far more favourable than their counterparts in the third or private sector. It is worth noting that where staff are employed directly by a local authority, staff turnover is far lower.”

PricewaterhouseCoopers (2013) concluded that, amongst a range of other factors, smaller providers in converted buildings were more vulnerable to the pressures facing social care providers. But as the 2011 collapse of Southern Cross and the on-going issues at the Four Seasons Group show, even larger corporate providers are far from immune.

Direct Payments / Personal budgets

SHA Cymru is concerned that service users do not always get the personalised, flexible care that they require. In some cases social services can be too bureaucratic, too big or cumbersome in the way they deliver a service. Equally there can be instances in which a service user and social services cannot agree which is the best package of care. If social services insist on providing a service in a way that is not "user centred" it may be refused or result in sub-optimal outcomes which will deprive a vulnerable citizen of their entitlement and deliver poor value for money.

In an attempt to address this over recent years the Welsh Government, though the SSWB Act , has been actively promoting individual payments / personalised budgets. As a consequence the number of users of direct payments has almost doubled to over 2,000 people. While SHA Cymru believes that personalised budgets have a role to play for certain types of service they should be seen as having a limited niche role rather than being promoted as a preferred care option.

In practice individual payments do not deliver individualised services. People are not offered direct flexible support, instead they are encouraged to take their budgets as cash and employ your own staff, even when this is burdensome. The situation is further complicated by the local authorities' continuing duty to ensuring that the recipients needs are being met.

Individual payments create their own unnecessary risks, costs and bureaucracy for patients and care providers. They are a further step away from public provision towards creating a market in care which frequently requires people to personally manage a budget and employ their own staff with all that that entails in terms of employment law. Extra support is provided to the service user to help them carry out these tasks but this will involve the use of resources that will have been diverted from front line provision.

In addition direct payments risk undermining pooled-risk, public service provision. Most individual payments are funded on "the average cost" basis. In practice most additional public services are provided at a marginal cost which is usually less than the average cost. As a consequence a big increase in the use of individual payments could reduce the overall sum of money available to the majority of service users.

Funding Models

As well as looking at the areas where funds are needed and what our priorities are we need to consider wider funding models.

Social care delivery in Wales is subject to a means test for both domiciliary and residential services. This is based on an financial assessment which looks at an individual's income and assets including the value of their home so long as they have no resident dependents.

Over the years the income and asset "disregard" has increased and it is more generous in Wales than in England. From April 2017 the Welsh Government increased the capital limit to £30,000 (increasing to £50,00 by end of this Assembly term) for residential care, but

opted to keep it at £24k for non-residential services. In addition in Wales there is a cap on the weekly cost of domiciliary care unlike in England. The current maximum charge from 10 April 2017 is £70 per week. As well service users can choose to opt to retain their assets in return for a charge or deferred payment to recover costs when they pass away.

In practice this means that about 80% of residential care homes residents and 44% of domiciliary care recipients (LE Wales 2014) are not charged for the services they receive. This has led some to argue that any radical change to the present system will only favour the rich and better off.

However many who pay for care have modest incomes and can face difficult financial choices until they reach the “disregard” thresholds. These choices are most difficult for those on middle level of incomes who have little scope to manipulate their financial affairs like the super-rich. It is important that public policy in Wales takes the needs of this group into account rather than focus on “anomalies” that might arise about free care for the 0.4% of the Welsh population who are millionaires. In these circumstances it is more important that a greater priority is given to tackling tax evasion by the super-rich and promoting a more progressive tax regime to support socially just public policies.

A recent report by the Older People's Commissioner (2014) said “ ...the current lack of knowledge about the number of self-funders in Wales living in care homes has an impact on the quality of life of older people as it is not clear what support and advice individuals are receiving and the extent to which or how the quality of care that self-funders receive is monitored.” This is neither fair or socially just.

It is inevitable that promoting a more socially just care policy will involve greater public expenditure. The 2017 Labour Manifesto promised to increase spending on social care by £8 billion in the next Parliament. On the other hand David Cameron, in response to the Dilnot Commission's recommendation of a £35,000 cap on care costs, proposed to implement a £75,000 cap by 2020. The Tories' subsequent chaotic proposals for a “dementia tax” at the last general election in 2016 showed that how confused their thinking is on this matter. The best we can now hope for from the UK Government is a green paper on care and support for older people by the summer 2018. This, it is claimed, will set out plans for how it proposes to improve care and support for older people and tackle the challenge of an ageing population.

A number of solutions, some more realistic than others, have been proposed to address this including:-

- Continue to increase the level of income and asset “disregards”. There could be variations in how this could be achieved e.g. exclude domestic homes from asset assessments or only take the average domestic home costs into account.
- Further reduce the maximum payment cap for domiciliary care.
- There could also be a maximum cap placed on residential care costs. This could be done on a weekly, annual or lifetime basis. Labour Party General election manifesto favoured this option.
- Provide a support payment against costs. This payment could be linked to the actual level of costs or level of income or a combination of both.

Some of these options would be feasible for the Welsh Government on the back of “Barnett consequentials” if public expenditure was to rise in line with the Labour's manifesto commitments.

SHA Cymru's favoured solution is a universal needs based service free at the point of use. In view of the cost involved it would not be possible to achieve this without a comparable initiative in England through the operation of the Barnett Formula or, even better, though a needs based funding transfer.

In recent years the Welsh Government has commissioned LE Wales to undertake a number of studies looking at the cost of various care options including providing free social care. It estimated that the 2013 cost of residential care was £238 million and that an additional £213 million would be needed to provide free residential care for those who were over-65 years old.

In the run up to the 2017 National Assembly elections Plaid Cymru came up with a plan to phase out all social care charges over a 10 year period. Plaid estimated that the cost of getting rid of getting rid of non-residential fees would be £32 million. So the total cost of a package to end all charges for those over 65yrs could be of the order of £245 million.

In Scotland social care funding is divided into continuing personal care costs and living costs. In July 2002 the Scottish Government introduced a policy of free personal care for those over 65 years at the cost of £107 million in the initial partial year, £143 million in the following full year with this sum increasing to £169 million in 2008 (Independent Review of Free Personal Care and Nursing Care in Scotland; Lord Sutherland Report 2008). It found that the biggest area of care growth over the first three years was a 60% increase in domiciliary care services.

Now the Scottish local authorities pay £171/ week to providers of residential care with an additional £78 for nursing care with residential or “hotel” costs being met by the service user themselves. A means test is used to fund full “hotel” costs of those with assessable assets of less than £16,250 with an upper assistance limit of £36,250. For those in receipt of full support there is a payment of £648.92 per week for nursing care (October 2016 - April 2017) and £558.71 per week without nursing care. So while personal social care is free in Scotland, residential care service users will still pay for living costs if they have assessable assets of more than £16,250.

When free personal care was introduced in Scotland the Attendance Allowance continued to paid for those in receipt of free domiciliary care but it was withdrawn from those who had free residential care thus saving the UK Government £25-30 million annually. This proved to be controversial at the time and there is still a campaign to have the Allowance restored for those in residential care which would reduce the cost of free personal care for the Scottish Government.

By 2015-16 78,000 people in Scotland benefit from Free Personal and Nursing Care with just under 31,000 of these people living in residential homes and around 47,000 receive domiciliary care. Domiciliary care now costs of £371 million. This is an increase of about 60% from the 2006-7 costs with the cost of residential care remaining largely static (Scottish Government 2017).

Over the years a range of other options have been offered to address the growing costs of social care short of a universal service funded from general taxation.

The Dilnot Commission (2011) suggested a lifetime cap of £35,000 on social care costs at a cost of about £1.7 billion with lesser payments based on means testing. In addition, depending on their means, people would also contribute to their living costs to a limit of

about £7-10,000/year.

The Barker Report (2014) proposed a greater amalgamation of all older people's spending including health, social care and social security to provide an enhanced social care service linked to increase public expenditure of £5 billion largely funded from increased national insurance payments and a wider review of taxation.

None of these options, or others that are less well-known, are deliverable solely within a Welsh devolution framework that is likely to exist in the immediate future. Changes will have to take place at a Westminster level to provide both the legal framework and the finances to allow progress.

In the more short term there is a case to consider the devolution of “older people's” benefits and public expenditure to the National Assembly. This would provide the Welsh Government with a greater level of resources and allow it to plan more imaginatively for the future of our older citizens. However there are pitfalls not least as a Tory Government might be willing to devolve the legal responsibilities linked to a continuing austerity budget.

Conclusion.
It is inevitable that the cost of caring for an older population will increase. In part this will be driven by demographic factors and by efforts to reduce the costs of the acute hospital care sector. These are legitimate objectives but they must not dominate our vision.

The Welsh Government has a range of policies and legislation in place that could provide older people with the prospect of more dignified, autonomous and higher quality lives. But in too many areas “intent” is not the same as implementation.

Already “austerity” and neo-liberal economics have undermined both the quality and quantity of services that people receive. It has also blurred the vision and blunted the ambition that we deliver a radically better future for our older citizens. Only a new commitment to policies underpinned by the principles of social solidarity and justice will allow us to achieve this.

Contact details

Tony Beddow
Secretary SHA Cymru Wales
[redacted]