

WORKING PAPER 01

social care 2020: what are the challenges ahead?

Dr Henry Kippin



2020 Public Services Trust
at the RSA

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Social Care for 2020: what are the challenges ahead?

Henry Kippin¹

This working paper explores some key characteristics of our current social care settlement, before laying out the basis of a new social care vision for 2020.

Social care is a complex, multi-layered and fragmented set of interventions. The term implies a diverse range of relationships not just between individuals and the state, but between individuals, families, carers, local authorities and the mixed market of providers delivering social care services.² For this reason, we should imagine social care not as a definition of a coherent system, but as a type of intervention³ that can take various forms. And as one might imagine, the assumptions and values that underpin this loose set of assumptions can be inconsistent, and sometimes contradictory.

The funding of social care is testament to this critique. In early years and in old age, social care provision is characterised by a resource split that places huge burdens on families and carers – both in terms of direct costs, and informal opportunity costs. As Howard Glennerster notes, “the largest element in the cost of caring for children, older people and other dependent citizens falls upon the family – mainly parents and spouses, but also other family members.”⁴ As we are now all aware, this dependency upon informal care⁵ – and the way social care policy is structured around this assumption – poses real problems for the future. How, for example, can we square the circle of an increasingly ageing (and thus potentially dependent) population, and the need for longer-term labour market participation to mitigate against the potential retirement ‘timebomb’ posed by our pensions deficit?⁶

The challenge of funding the future of long-term adult care is massive, already constituting 59% of gross council expenditure on adult social care.⁷ But it is not

the only element of social care that demands a new vision. Throughout earlier periods in the life-cycle, people's needs are often complex, interlocking, and mutually reinforcing – as a recent Institute for Public Policy Research (IPPR) report (produced in conjunction with social care organisation Turning Point⁸) noted:

“People with complex needs may have to negotiate a number of different issues in their life, for example learning disability, mental health problems, substance abuse. They may also live in deprived circumstances and lack access to stable housing or meaningful daily activity... There is no generic complex needs case.”⁹

Social care provision in the UK reflects this complexity – but not necessarily in a way that benefits the individual.¹⁰ We are currently some way from a vision of a personalised, easily navigable system of care for people with complex needs¹¹, wherein those in need (and/or those providing informal care) can access good quality information about the services and support available to them, and understand clearly how these services might be paid for. We should also ask why we talk about providing a particular service at all in some cases. The question of when we commission particular services, and when we afford individuals jurisdiction over individual budgets, is at the heart of transforming social care through the life-cycle – from something done to individuals, to a set of interventions designed and controlled in large part (and where appropriate) by individuals and families themselves.

A vision for 2020 must pull together creative thinking on the role of individuals, families, service providers and commissioners. It must put the individual at the centre of this thinking, asking how interventions throughout the life-cycle can be re-imagined to support and enable, in a way that our current, fragmented collection of interventions does not. This will mean reconfiguring the way we think about social care – a shift from a set of ill-understood and sometimes outlying services, to the glue that binds education, health, housing, employment and other public services together. A first step towards this should be a process of extracting and questioning the values and principles that drive current care models. Following this, we can determine the new principles upon which the future of social care should be founded.

Key Themes Underpinning the Current Settlement

Lack of a Distinct Institutional Identity

The Department of Health (DoH) recently classified social care as ‘the mixture of financial, practical and emotional support that helps people to do the everyday things that most of us take for granted’.¹² Such a definition illustrates the nebulous

nature of the sector – difficult to define, encapsulating a diverse set of interventions that are provided by a mixture of organisations. Such diversity reflects the complex needs of individuals, families and communities, but institutional complexity is also inherently problematic, contributing to poor outcomes for citizens through being led by services rather than individual needs.

Possibly as a result of this diversity of interventions and service providers, the sector has suffered from lack of ‘visibility’, despite the public placing relatively high priority on care of the elderly and social services.¹³ According to the IPPR, this is ‘a consequence of the fact that (the sector has) no obvious institutional identity’¹⁴. A good contrast is with healthcare, a sector that enjoys high public profile (and sustained funding), bolstered in part by influential professional institutions.

The relative invisibility of social care can also be seen as a legacy of historical inattention. As John Glasby has written recently, ‘social care and social work’ could be seen as falling outside the remit of Beveridge’s original five giants. He asks: “is social care responding to a sixth giant that Beveridge failed to identify? Is it the glue that holds the other five together? Or is it a crisis service that works with people who fall through the gaps in other services?”¹⁵ Certainly many people overlook society’s need for social care – and indeed what the term actually means in terms of service interventions – until their lives are directly affected by it.

This lack of a distinct institutional identity has implications for the level at which we provide (and fund) social care – with direct consequences for the individuals and families affected at different stages. In 1999 the Royal Commission on Long Term Care highlighted the often arbitrary distinction made between the way care for types of conditions are funded – finding ‘no justification’¹⁶ for certain boundary lines between long term NHS care (where costs are met by the taxpayer) and other long-term social care needs (where costs are met by individuals). This lack of consistency has led to some recent calls for a new set of social care principles¹⁷, or a social care constitution.¹⁸

Costs of Care are (unfairly) Shared

A significant element of the cost of social care is provided by individuals and/or their informal support networks. This burden – which Glennerster estimates at about one third of the total cost of social care interventions – encapsulates both direct and indirect costs, and can place high demands on families with limited resources. Although some continue to argue for comprehensive provision at the point of need, political consensus generally exists around the principle

of co-payment for care services.¹⁹ Yet the current system (underpinned by a philosophy of ‘progressive’ or ‘targeted’ universalism) is seen to allocate state support unfairly in some cases, and is not necessarily reflective of contributions made by individuals and families throughout their working lives. The 2009 DoH green paper recognises this in setting out overcoming disputes over ‘who gets what’ as a key policy challenge. It argues that

- “Many people do not get help from the state towards paying for their care and support
- State-funded care and support is often provided only when people have already developed high levels of need
- People with the same needs receive different levels of care depending on where they live”²⁰

These concerns over unfair resource allocation are exacerbated by the existence of an effective postcode lottery over ‘entitlements to state-funded care’²¹ across the UK, which itself undermines the ability of individuals to address their own needs effectively. As Keen (2008) argues, ‘if citizens do not know what the state will and will not provide, then they cannot make informed decisions about payment for their own care.’²² A quote from a recent evaluation by the Commission for Social Care Inspection (CSCI, now Quality Care Commission (QCC)) illustrates the frustrations caused by such variance:

“The postcode lottery generates confusion and dissatisfaction among service users and carers, who do not understand how a system called ‘fair’ can result in the same level of need being met by provision of social care in one local authority and not another.”²³

The assumption that payment for social care interventions should be shared between individual and the state is at the heart of recent attempts to re-configure the way long-term adult care is funded. Both the 2006 Wanless Social Care Review and ‘Shaping the Future’ place a ‘partnership’ model at the heart of their proposals, largely eschewing the suggestion that increasing costs should be absorbed as part of general taxation. As John Hills observed in 2003, funding public services in the future will essentially be a negotiated mix of three options: ‘spreading the jam more

thinly; increasing the amount of jam'; and 'waiting longer for the jam'. In this case, each option implies a trade off between individual liability and pooled risk.

Debates over the funding of future social care have been largely framed in terms of care of the elderly (and as the Economist noted recently, age-related costs are expected to 'dwarf' the impact of recession and low economic productivity²⁴). But as evidence from Turning Point has shown, demographic change means that the needs of our ageing population may not correspond to our traditional perceptions – people are living longer with learning disabilities for example.²⁵ In fact statistics suggest that the number of people with severe learning disabilities is set to increase by around 1-5% per annum for the next 15 years.

Such trends will force us to think about the costs of ongoing specialist support for complex needs in a way that challenges our existing assumptions about the type of care needs people have across the life-cycle.

Fragmented Services and Uneasy Transition between Stages

Social care by its nature is a complex and interrelated set of interventions. Yet this sense of disjoint – between services, across age groups, and between types of treatment – is accentuated by the often unclear boundaries between state and voluntary responsibility, and arbitrary breaks in responsibility for individuals during key 'transition' phases of their lives. Those with multiple care needs will often suffer from the need to continually re-articulate their needs to different agencies. These are 'people who are forced to knock on several different doors and tell their story over and over again, and are at the receiving end of services that don't link up with each other'.²⁶

Key to creating this unhappy situation has been the assumption that the individual is responsible for joining up this mix of services, not the providers themselves. And this mix is not only one of traditional 'social care' services – rather complex needs often require a combination of social and other welfare services such as the employment our housing service. As Glendenning and Bell argue, fragmentation 'creates difficulties...in managing the interfaces between social care and other essential services such as housing, healthcare and social security benefits'.²⁷ The 'hazy boundary line'²⁸ between social care and healthcare (for example) is thus a logistical issue, as well as having big funding implications.²⁹

As well as negotiating a 'lumpy' set of care services, individuals are also subject to some fairly arbitrary assumptions about entitlements at different stages in their

lives. For example, young people may be entitled to a range of services appropriate to their age bracket, but then ‘fall off a cliff’ when they reach the lower age bracket in their local authority for adult services. Young people with alcohol or cannabis-related problems might be entitled to help in dealing with substance misuse, but transition into adult services may well see these problems subsumed under a focus on more socially unacceptable Class A drugs.³⁰ Such fragmentation is still evident, despite Government recognition of the need for more sophisticated, or ‘extended’ transitions to adulthood since 1997.³¹

We should also throw open to question inconsistencies that underpin the way we address different types of need; of which mismatch between substance and alcohol misuse is the clearest example. Currently alcohol misuse is treated far less consistently and seriously than drug misuse. An individual convicted of a crime might undertake a tailored sentence that dovetails with a drug rehabilitation programme, but this type of support is rarely offered to those with alcohol problems. Bearing in mind the costs of such problems to the NHS and the criminal justice service in particular, this could be an area in need of a policy re-think.

Lack of Adequate Information

A recent paper by Dr Foster Intelligence and Turning Point set out the problems created by a lack of consistent and good quality information (or ‘customer insight’) across public services.³² In a sector where individual needs are often complex and overlapping, this lack of adequate customer insight causes real problems for those commissioning social care services, as well as for those consuming them.

On one level, this is a function of the unexpected need for social care in some cases. As Glendenning and Bell note, ‘few people will seek out information in case of the unpredictable and unwelcome future eventuality... this leaves potential users very unprepared’³³ (and potentially subject to selection bias from some providers). Demand for bespoke information may thus be underdeveloped, but we know that the inability to make quick decisions based on agglomerated personal data makes it difficult for health and social care professionals to work towards preventative interventions (and therefore potentially save money on acute treatment). As Tim Kelsey argued recently

“preventative measures are... hindered because local public services aren’t allowed to share data between themselves. Patient records, for

example, aren't linked to the benefits data. As a result local authorities don't know which GPs commonly sign people off work. Yet if it was known that one GP had, for instance, an unusual number of patients claiming incapacity benefit because of mild mental illness, the health service could work with that practice to introduce more effective workplace health schemes... or design better mental health services."³⁴

Concerns over privacy, as well as data quality and consistency are valid; but it is clear that better use of quality information will be key to commissioning personalised services, and enabling meaningful citizen choice.

The Low Status of Social Carers

A fourth key set of assumptions underpinning the current social care model concerns the social status – and, concurrently, the remuneration – of carers. Traditionally, those providing formal front line care (estimated at around 1.5 million workers)³⁵ have been poorly paid, worked in difficult conditions, and have been exposed to limited opportunities to augment their skills and qualifications through training. Accordingly, the public appear to perceive social carers as providers of an 'invaluable' service, but one that is 'not appealing as an (employment) option for the majority'.³⁶

Informal care appears to be similarly undervalued, with carers generally receiving low levels of benefit (certainly in salary-replacement terms), despite the value of the support they provide being estimated at some £87 billion a year – more than the annual NHS spend in 2006-7.³⁷ Underpinning this lack of institutional (and financial) support is a model that treats the carer instrumentally – as a 'taken-for-granted' resource, rather than a model that meets the individuals needs more comprehensively, or even recognises the needs of the carer as well as the individual being cared for. According to Glendenning and Arksey, 'until (this) conceptual model underpinning policy shifts, it is likely that carers will continue to experience negative outcomes in their health, employment and finances'.³⁸

As the International Longevity Centre (ILC) points out, mitigating this confluence of 'excessive' demand for care and its low relative valuation will inevitably require an increase in the amount of care provided formally, which will require some creative thinking over future funding models.³⁹ This challenge will be taken up in greater depth below.

We can see that current social care models are characterised by a lack of distinct institutional identity and public understanding, a sense of fragmentation, confusion and unease over local variation, and an inability in many cases to enable individuals to construct and pay for the packages of care they need. These problems are in part reflected in the incremental nature of changes in the design, funding and provision of social care interventions. Clearly the sector has suffered from both an inability to address complex needs across siloed institutions, and faces a funding crisis unless a consensus can be built around the need for radical reform.

Three Principles for 2020 Social Care

A social care sector that is so complex and multi-dimensional hardly lends itself to easy characterisation or a snappy set of solutions. A detailed set of policy recommendations are not presented here. What we can present, however, is a set of three principles, driven by our critique and other emerging evidence and innovation – offered as a basis for a progressive social care settlement for 2020. The diagram below sets out these principles as (1) social care built around the needs and that builds the capabilities of citizens; (2) social care that values and mobilises private, social and non-market resource; and (3) social care that is fairly and sustainably funded. The following section will develop these in turn.

Principle	Policy Ideas
Social Care built around the needs, and that builds the capabilities of citizens	<ul style="list-style-type: none"> • Personalisation and budget autonomy • Segmentation and linked up data • Single point commissioning and connected care • Cross-service coordination and personal advisors
Social Care that values and mobilises private, non-market and social resource	<ul style="list-style-type: none"> • Broaden the definition of resources • Focus on relationships and networks for preventative interventions • Social circles and time-banks • Space for local innovation
Social Care that is fairly and sustainably funded	<ul style="list-style-type: none"> • Build on the partnership principles developed in Wanless and the 2009 green paper • Formalise and value informal resources • Explore options for flexicurity-style 'insurance' contributions and incentives • Explore local as well as national funding options

1. Social Care built around the needs and that builds the capabilities of citizens

The idea of citizen-centricity has been at the heart of recent debates on the future of public services. The concept that services should be more receptive to individual need, and shaped more tangibly around the lifestyle of the individual is relatively uncontroversial in theory – yet practical advances in this area have the potential to radically re-shape the way social care is experienced by citizens. A truly citizen-centric model would see budget responsibility and the commissioning of services devolved to the lowest practicable level, so that the interface between citizens and social care services (which is often currently shaped around the needs of service deliverers), is transformed. Such an agenda faces serious institutional and legislative barriers to change, but emerging evidence suggests that personalisation has transformative potential:

a) Personalisation and Budget Autonomy⁴⁰

Although international evidence on the impact of individual budgets is still fairly limited, a growing number of studies suggest that the personalisation of social care plans through individual budget autonomy can help deliver better value from services for citizens, as well as efficiency gains over the long term.⁴¹ As a recent Demos report argues, ‘savings are made when people use personalised services because money is targeted more efficiently at peoples needs, which increases allocative efficiency’.⁴² As well as citizens better matching services to their own needs, research from the US has indicated that budget autonomy has also created incentives towards preventative and early intervention⁴³, potentially reducing the need for acute NHS intervention further down the line.⁴⁴

Recent feedback on the Putting People First programme⁴⁵ from Oldham indicates that many social care workers also recognise the benefits of increasing citizen autonomy. According to a Guardian survey, ‘70% agreed that PPF would benefit both users of services and carers’, with 59% expecting a ‘positive impact on their own role’.⁴⁶ Nevertheless, the institutional, legal and cultural barriers to transformation in this area should not be underplayed. Personalisation requires a fundamental shift in the balance of entitlement and responsibility between citizens and the state, and delivering personalised social care will challenge traditional boundaries between services and sectors (for example, between centrally-funded NHS and locally allocated social care services, or between public, voluntary and private sector providers), as well as the culture, incentives, and day-to-day role

of public service managers and deliverers.⁴⁷ As a recent report from one county council noted, 'scaling up from pilot to full-blown self-directed support (SDS) requires a complete metamorphosis of systems and culture'.⁴⁸

b) Breaking Down Traditional Service Boundaries

The idea of building social care services around the needs and capabilities of citizens is antithetical to a set of bounded public services, each with departmental budgets and a concomitant set of service priorities and delivery targets. For individuals, this effectively means telling their story multiple times, to multiple organisations. As the 2009 DoH Common Assessment Framework recognises, this is inefficient, but also engenders a sense that information given by citizens is not properly valued by service providers.⁴⁹

According to Dr Foster and Turning point⁵⁰, three key steps are obvious here. Firstly, use segmentation to develop deeper insight into the 'needs, preferences, lifestyles and patterns of service usage' within communities. Where individual budget autonomy is not appropriate, this would facilitate the commissioning of more joined-up local public services. Secondly, a consistent approach to data usage should be applied across public service agencies. This would increase the usefulness of data across departments, and discourage duplication and over-laying over data. Thirdly, this data should be 'linked up', making it easier for agencies to match individual needs to the range of services available locally.

Working across traditionally defined agencies is perhaps the biggest challenge facing a citizen-centric model of social care. As well as using and sharing information better, public service agencies will need to transform embedded incentive structures, and shift to models of commissioning based on complex and cross-cutting social outcomes. For example, enabling an individual to realise their social and economic potential might require social care, health, education, employment and criminal justice interventions. The Connected Care model is a nascent example of how this process can be encouraged within a locality – building care interventions around a community 'audit'⁵¹ that enables commissioning from a 'common set of values'.⁵²

The challenge for policymakers is to mesh together two approaches that see the individual quite differently. Individual budget autonomy suggests that people are given the capacity to put together their own package of services, based on their own needs and priorities. In this scenario, individuals are the commissioners, doing the joining-up of services themselves. A 'connected care' model suggests

that individuals would be the beneficiaries of sophisticated, joined-up service plans, but would not be the ones joining-up the services themselves. Some radical thinking could pull these approaches together, perhaps giving individuals choice over personal advisor or commissioner as part of a wider individual service budget working across services. The 2020 Commission is currently developing some ideas in this area.

2. Social Care that values and mobilises private, social and non-market resource

We have seen that a radical vision for social care would re-think the way that public spending is allocated, and the way that local services are commissioned and delivered. It would be far more joined-up in assessing the needs and capabilities of communities, and would look to more efficiently match public and private spending with better outcomes for individuals. But reconfiguring existing, formalised resource is only half of the job. In future, we must be far more creative about mobilising informal, non-market resources, and base our funding and service delivery models on a much better understanding of what citizens can bring to the table.

London-based consultancy Participle has cogently argued that real change in the way our current care system works will require a much broader definition of resources – ‘to combine public, private and voluntary resources’.⁵³ Many social care interventions reflect a breakdown or deficit in relationships and social participation, but our existing service configuration does little to encourage social capacity to address these problems. Rather, it focuses on narrowly providing services for the individual, often ignoring fundamental ‘social connections’ that can ameliorate social breakdown. According to Hilary Cottam, ‘this is a deep challenge of social reform. Public services need both to be based around social networks...and designed to foster these relationships’.⁵⁴ Participle’s successful Southwark Circle initiative is built around these principles.⁵⁵

Better mobilisation of non-state resources is not only socially beneficial, but can also save money in the long term – both through bringing undervalued resources to bear, and through targeting these resources at the early intervention and prevention stages. Such resources – social circles, or caring time-banks for example - are currently outside of the sphere of public spending, yet could dramatically reduce the cost of chronic conditions further down the line.⁵⁶ As the Joseph Rowntree Foundation (JRF) have argued, formalising some of the support mechanisms currently being provided informally by carers could help pay for the increasing costs

of long-term care.⁵⁷ They argue that ‘those leading the transformation of (social care and wider public) services need to invest in innovative and flexible use of local resources that harness the solutions and ideas of local communities’. Under these conditions, social carers (and especially those providing care informally) would become a more valued community resource. That said, the authors are clear that such investment would need a qualitatively different approach at the coal face: ‘a wholesale shift away from traditional, risk averse commissioning practices, and strong leadership from national policy through to local delivery’.⁵⁸ Charlie Leadbeater describes this shift as one ‘from care to wellbeing, income to participation, consumption to relationships’.⁵⁹

3. Social Care that is Fairly and Sustainable Funded

Addressing the issue of funding for social care requires an articulation of current system failure, but also an estimation of the demand pressures ahead. We have already argued that the current model is inconsistent, often unfair, and does not incorporate a wider set of (currently) non-market resources that could be integrated with (and augment the value of) public spending. And the cost of facing up to the social challenges ahead is daunting. NESTA estimate the cost of mental ill-health at over £110 billion per year; the cost of alcohol abuse at around £20 billion; the combined costs of an ageing society – which the Economist recently called ‘a slow moving but relentless development’⁶⁰ – at £300 billion by 2025.⁶¹

Being creative about resources can mitigate some of these costs. Early and preventative intervention can be encouraged through formalising informal networks, and through moving towards individual budget discretion where appropriate. Personal advisors or service brokers can help generate more efficient and more valuable outcomes for citizens. Where individual budgets are inappropriate, community auditing, quality information and intelligent, cross-departmental commissioning can deliver better and more cost-effective service plans. But as well as this re-deployment and mobilisation, the future of adult social care in the UK will require new ways to raise revenue. The question is then about where this comes from. The 2009 Government green paper thus asks: ‘what should the balance of responsibility be between the family, the individual and the government?’

Long-term elderly care is only one aspect of the whole range of care needs people have across the life-cycle, but the sheer scale of paying for this aspect within the context of an ageing society has begun to catalyse some serious attempts to

address the question above. These have attempted to negotiate the basic need to spend more money on social care, to increase the risk pool (so that social care becomes a commonly insured risk in line with other public services such as health), and to pick out a fair division of responsibility between public and private spending.⁶² As the ILC has noted, ‘whatever balance of formal and informal care emerges...a greater proportion of the country’s wealth, both private household wealth and public spending, will have to be allocated to the task of paying for formal care’.⁶³ This is not only true of elderly care either – as an open letter to the Guardian from several members of the Learning Disability Coalition reminded the government in July.⁶⁴

The New Partnerships?

Both the Wanless Review and the 2009 green paper place the idea of partnership squarely at the centre of potential future funding models. It is worth looking at how this is proposed:

- Wanless’s partnership model suggests a ‘free-of-charge, minimum guaranteed amount of care’, above which individuals would make matched contributions to make up the remainder of their ‘package’. This model would require individual contributions to care, but from a higher bar of state contribution. This model, however, brings a ‘significant increase’ in public spending, from £6.2bn to £9.7bn.⁶⁵
- The 2009 green paper floats two variations on this approach. One is an insurance system, whereby people could choose to purchase optional insurance to cover non-state provided costs. The insurance would mean any state provided care over and above this bar would be free of charge.
- Another option is the ‘comprehensive’ model, which would require ‘everyone over 65’ to pay in (provided they could afford to), increasing the risk pool, and allowing free care to be provided for everyone.

All of these options look to offer a fairer settlement in some way. They offer the chance for people to avoid spending down their life savings⁶⁶, and look to increase money going into the sector without absorbing the cost within a politically unacceptable (or financially unsustainable) rise in general taxation.⁶⁷ A 2020 vision might therefore use the partnership principle as its starting point, asking how the cost of this insurance or comprehensive cover could be spread across a working

life (re-establishing a contributory principle, for example), or rolled into a European-style flexicurity system that encourages individual insurance contributions to protect against multiple risks through the life-cycle.⁶⁸ Earlier this year Counsel and Care suggested a ‘care duty’ that would be levied on estates after death - effectively a hypothecated inheritance tax that would, if applied over a threshold of £25,000 - raise ‘an additional £1.7 billion’ per year.⁶⁹ For those unable to contribute personally or through employers, a combination of means testing and recognition of informal (social) contributions could maximise participation and broaden the risk pool.

Reflections on some key challenges ahead...

This discussion paper has attempted to pick apart our current social care settlement, offering a critique of several underlying problems, and some long-standing and fundamental tensions. It has then used this critique to inform a vision for 2020 – a vision that builds care structures around the needs of citizens; that enhances their capabilities; that mobilises the whole range of formal and informal resources available to citizens and their communities; and that is funded fairly, and sustainably. Yet this vision throws up as many questions as answers. How, for example, could mindsets be shifted to facilitate an insurance-based funding model? How could we reconcile individual budget autonomy and truly local commissioning within a nationally funded system? And how can we be truly radical when political expediency imposes its priorities? Some of these tensions are explored below:

1. Prevention versus Cost-Pressure

Shifting social care and healthcare towards prevention is the oldest new idea in town. Yet getting to what Participle have called ‘universal preventative services’ involves some potentially difficult trade-offs at the front end. First, it means that we must be open to some innovative and unusual use of resources. An anecdote from Minister for Care Services Phil Hope: “a retired gentleman suffering from mental health problems...used his budget to buy a dog. It got him out of the house, got him meeting people, rebuilding his confidence and rebuilding his links with the community”.⁷⁰ This is hardly a traditional use of social care budget, but a creative solution with huge preventative potential (indeed, ACEVO have recently called for personalisation (in a broader sense) to be scaled up as a ‘coherent, system-wide approach’ across public services).⁷¹ Second, prevention inevitably requires trading-off greater up-front spending with savings over the long term. Within a financially

constrained environment, this choice is difficult for decision-makers to sanction even when good ideas are presented.⁷²

2. Radicalism versus Political Expediency

The effective ring-fencing of the NHS budget exposes a key tension for social care, and across the board for public services: how can policymakers be radical when political decision-making is so contingent upon public opinion? For instance, a radical proposal might deconstruct health and social care spending together on the basis of a chronic/acute distinction, or according to the arena in which individual needs are met (home, community, hospital et cetera)⁷³. The ring-fencing of budgets renders such an approach impossible, as it locks in existing funding patterns and service boundaries, making more radical change more difficult to imagine.

3. Local versus National

The previous pages have shown how local-national discourse is woven through debates on the future of social care – especially the question of what level is appropriate for its funding and provision. The postcode lottery is a condition of local authority jurisdiction over service allocation and provision, yet the funding models proposed in the 2009 green paper are national. The government (and opposition parties) recognise the value of localised decision-making and delivery of care services, yet it is this locally-produced variation that is so often deemed unfair.⁷⁴ The current mainstream debate is over new settlement based on expanding the funding base nationally, whilst advocating local delivery of social care services. The JRF note that ‘under the fully national system, the onus is very much on national delivery and funding mechanisms. Local authorities would focus on provision: assessing clients and commissioning services. They would have no role in collecting resources to pay for care, through council tax or other mechanisms’. This would rule out (for example) more radical schemes such as local insurance schemes or ‘variations in tax rates’.⁷⁵

4. Nudge versus Nanny?

The problem of paying for social care in the future taps into a debate currently being played out between our political parties – over a state that nudges (through designing appropriate choice architecture and providing behaviour-changing incentives), versus one that nannies (applying top-down solutions to social problems through embedding entitlements and making national commitments). Creative

thinking about the future funding of social care might find a solution in-between these crude characterisations, perhaps with a national funding model that uses soft compulsion to encourage insurance contributions. Certainly the green paper leaves open some key questions over how and when individuals might contribute to a comprehensive model: perhaps upfront through regular contributions during younger working years, perhaps post mortem, or even through a combination of monetary and non-monetary, informal contributions. Such questions will have wider significance in the years to come.

Endnotes and References

- 1 Henry Kippin is Commission Manager at the 2020 Public Services Trust. Thanks to Lord Victor Adebowale, Stephen Burke and Emily Frith for advice and input, and to Jeff Masters and Paul Buddery for comments. All errors & opinions remain those of the author, who writes in a personal capacity.
- 2 We should also remember that social care covers a wide range of interventions across different age groups and needs. Residential care of the elderly or interventions on behalf of children are often most prominent within the public consciousness, but the range of social care interventions is broad – including care services for physical disabilities, mental health issues, drug or alcohol dependency, and targeted services for specific ethnic and age-related needs. For a recent discussion on the challenges of mapping this range of needs onto consistent funding models, see Forder, J. (2008) *The Costs of Addressing Age Discrimination in Social Care* University of Kent, Personal Social Services Research Unit Discussion Paper no. 2538
- 3 Which can be defined as a psycho/social intervention to reconnect or retrain individuals' ability to function according to certain societal norms.
- 4 Glennerster, H. (2003) *Understanding the Finance of Welfare: what welfare costs and how to pay for it* Bristol, Policy Press p.81
- 5 In many cases, tightened eligibility criteria for social care services has meant an even greater reliance on informal care for those with low or moderate needs. See for example Commission for Social Care Inspection (CSCI) (2008) 'Cutting the Cake Fairly'; and CSCI (2009) 'The State of Social Care in England' 2007-8
- 6 See for example Barrell, R., Hurst, I. & Kirby, S. (2009) 'How to Pay for the Crisis or Macroeconomic Implications of Pension Reform' London, NIESR and Hills, J. (2004) *Inequality and the State* Oxford, Oxford University Press
- 7 CSCI (2009) 'The State of Social Care in England' 2007-8 p.17
- 8 For more information, see <http://www.turning-point.co.uk/whoarewe/Pages/aboutus.aspx>
- 9 Rankin, J. & Regan, S. (2004) 'Meeting Complex Needs: the future of social care' London: Institute for Public Policy Research
- 10 I.e., the system reflects the complexity of social care needs, but also an institutional complexity due to variance in local eligibility criteria, separate budgets for service areas (health, education etc), and commissioning that reflects these siloed services.
- 11 The CSCI note that 'there are diverse understandings and definitions attached to the concept of 'multiple and complex' needs. This complexity relates to multiple needs associated with multiple impairments, the severity of need, and challenging behaviour. How complexity is defined can have a significant impact on how people's needs are perceived and how support is constructed'. See CICS (2009) 'State of Social Care', p.116
- 12 Department of Health (2009) 'Shaping the Future of Care Together' London, DoH p.29
- 13 Ipsos MORI (2009) Public Spending Index, accessed at <http://www.ipsos-mori.com/researchpublications/researcharchive/poll.aspx?oltemId=2374>
- 14 Rankin, J. & Regan, S. (2004) Meeting Complex Needs' p.2
- 15 Glasby, J. (2008) 'Social Care' in Alcock, P., May, M. & Rowlingson, K. (2008) (eds) *The Students Companion to Social Policy* (3rd Edition) Oxford, Blackwell p.351 In fact, many would argue that social care interventions can be some of the most effective preventative measures in public health and wellbeing. Examples here? Rightcare?

- 16 Royal Commission on Long Term Care 1999, Ch.6 para 34-5 – quoted in Keen, J. (2008) *Does Anyone Care About Fairness in Social Care?* London: Joseph Rowntree foundation
- 17 See Keen, J. & Bell, D. (2009) *Identifying a fairer system for social care* London, Joseph Rowntree Foundation Viewpoint
- 18 See Bartlett, J. & Guglielmi, S. (2009) 'A Constitution for Social Care' London, Demos
- 19 Although there is still widespread misconception within the wider public that social care is provided 'free'.
- 20 DoH (2009) 'Shaping the Future of Care' p.42 Counsel and Care have called this a 'triple lottery' of care services. See for example Counsel and Care (2006) 'Care Contradictions: higher charges and fewer services' London, Counsel and Care
- 21 See Lloyd, J. (2008) 'Funding Long-Term Care: the building blocks of reform' London, International Longevity Centre – UK
- 22 Keen, J. (2008) 'Does Anyone Care about Fairness in Adult Social Care?' London, Joseph Rowntree Foundation p.11 A new report from Demos notes that 'unlike other postcode lotteries, it's not an issue of service quality. Where you live can make the difference between your receiving the help you need to live your daily life, or receiving no support whatsoever.' See Bartlett, J. & Guglielmi, S. (2009) p.5
- 23 Commission for Social Care Inspection (2008) *Cutting the Cake Fairly: CSCI review of eligibility criteria for social care*, CSCI October 2008 p.36
- 24 See The Economist (2009) 'A Slow Burning Fuse: special report' 25th June 2009, accessed online at http://www.economist.com/specialreports/displaystory.cfm?story_id=E1_TPRRRDQV
- 25 DoH (2001) 'Valuing People: a new strategy for learning disability for the 21st century' Thanks to Turning Point for this observation. ONS research also showed this week that the average age of deaths from cocaine and heroin overdoses is climbing (to late 30s), challenging perceptions of habitual drug use being a principally 'young persons' problem. See Bowcott, O. & Gabbatt, A. (2009) 'Sharp rise in fatal cocaine and heroin overdoses, discloses ONS' The Guardian 26th August 2009. Accessed online at <http://www.guardian.co.uk/world/2009/aug/26/overdose-deaths-drugs-statistics>
- 26 Turning Point & Dr Foster Intelligence (2008) *A Personal Approach to Public Services: shaping services around individuals needs* p.16
- 27 Glendenning, C. & Bell, D. (2008) 'Rethinking Social Care and Support: What can England learn from other Countries?' London, Joseph Rowntree Foundation Viewpoint p.11
- 28 Glennerster 2003: 97
- 29 Collins argued recently that 'the current fault line between what is deemed a continuing health need and a social care need will be increasingly challenged, for example those older people with dementia who are deemed ineligible for ongoing health care. See Collins, S. (2009) 'Options for care funding: what could be done now?' London, Joseph Rowntree Foundation
- 30 Thanks to Turning Point for this example
- 31 Coles, B. (2008) 'Young People' in Alcock, P. (2008) et al *The Student's Companion* p.387 & see also 'Transition to Adulthood' work at <http://www.t2a.org.uk>
- 32 Turning Point & Dr Foster Intelligence (2008) 'A Personal Approach' and also Kelsey (2009) 'Long Live the Database State' *Prospect Magazine*, 29th July 2009. Accessed online at <http://www.prospectmagazine.co.uk/2009/07/longlivethedatabasestate/>
- 33 Glendenning, C. & Bell, D. (2008) 'Rethinking Social Care' p.3
- 34 Kelsey, T. (2009) 'Long Live the Database State'
- 35 CSCI (2009) 'State of Social Care' p.102
- 36 DoH (2001) *Perceptions of Social Work and Social Care: report of findings*. Report for the DoH prepared by Research Works, March 2001
- 37 Glendenning & Arksey (2008) 'Informal Care' in Alcock, P. (2008) et al *The Student's Companion* p.219
- 38 *ibid*, p.224
- 39 Lloyd, J. (2008) 'Funding Long Term Care' p.5
- 40 For a good introduction to the terminology and policy nuance within the area of personalisation and self-directed-services, see a recent briefing from the ACEVO Commission on Personalisation, available at <http://fullcostrecovery.3wise-dev.com/uploads/files/Briefing%201.pdf>
- 41 See for example IBSEN (2008) *Evaluation of the Individual Budgets pilot programme: final report* London, DDoH & University of York evaluation; social care institute of excellence, In Control & BMJ

- 42 Bartlett, J. (2009) *Getting More for Less: efficiency in the public sector* London: Demos p.14
- 43 Carr, S. & Robbins, D. (2009) 'The Implementation of Individual Budget Schemes in Adult Social Care' Research Briefing, Social Care Institute of Excellence.
- 44 In some cases, individuals using individual budgets have actually used more services, as personal responsibility elucidates previously unmet needs. This costs more in the short term, but the longer term saving through early intervention and chronic illness mitigation is potentially greater.
- 45 See DoH (2007) 'Putting People First: a shared vision and commitment to the transformation of adult social care' London, DoH available at https://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_081118
- 46 Jackson, L. (2009) 'The Choice is Yours' *The Guardian*, 28th Jan 2009, accessed at <http://www.guardian.co.uk/society/2009/jan/28/putting-people-first-adult-care>
- 47 Extending the principle of personalisation implies a visible role for personal advisors or support brokers, who would be responsible for helping individuals and families to navigate the social care and other systems.
- 48 Haworth, K. (2009) 'Self-Directed Support in Lancashire: an interim report' Lancashire County Council, In Control scheme p.39
- 49 Department of Health (2009) 'Common Assessment Framework for Adults' London: DoH p.7
- 50 See Turning Point & Dr Foster Intelligence (2008) p.8-11
- 51 Turning Point Briefing: What is Connected Care? Accessed at <http://www.turning-point.co.uk/commissionerszone/centreofexcellence/Pages/connectedcareresources.aspx> See also Harris, M. & Albury, D. (2009) *The Innovation Imperative: why radical intervention is needed to reinvent public services for the recession and beyond* NESTA Lab, March 2009
- 52 Dinsdale, P. (2008) 'Integrated Care Connections' *Health Service Journal*, 8th September 2009. Counsel and Care have also called for a 'single community support based system focused on the health and wellbeing of the local population'. See Counsel and Care (2008) 'Lifelong: a new vision for the wellbeing of all older people, their families and carers' London, Counsel and Care p.21
- 53 See Participle – Our Projects: Southwark Circle at <http://www.participle.net/projects/view/5/101/>
- 54 Cottam, H. (2008) 'Beveridge 4.0' Participle, available online at http://www.participle.net/images/uploads/Bev_4_final.pdf
- 55 See for example Leadbeater, C. (2009) 'State of Loneliness' *The Guardian*, 1st July 2009
- 56 The cost of depression, for example, was estimated in 2003 at £9 billion. See Hawkes, N. (2003) *Research Reveals the £9bn Cost of Depression* *The Times*, 1st December 2003. Accessed online at <http://www.timesonline.co.uk/tol/news/uk/health/article1031108.ece>
- 57 Examples given by the JRF are 'time-banks' and 'circles of support'. David Halpern discusses some of these ideas in his forthcoming book 'The Hidden Wealth of Nations'.
- 58 Gandhi, K. & Bowers, H. (2008) "Duty and Obligation" – the invisible glue in services and support' Joseph Rowntree Foundation Viewpoint
- 59 Leadbeater, C. (2009) 'Sam and May's Recipe: a lifetime of consuming is no preparation for old age' in Bedell, G. & Young, R. (2009) *The New Old Age: perspectives on innovating our way to the good life for all London: NESTA p.??* Such a shift is also proposed on a meta-scale by the Sarkozy Commission – the 'Commission on the Measurement of Economic Performance and Social Progress'. For more information and to download the report, see <http://www.stiglitz-sen-fitoussi.fr/en/index.htm>
- 60 See 'A Slow Burning Fuse' Special Report on Ageing Populations *The Economist*, 25th June 2009
- 61 Harris, M. & Albury, D. (2009) *The Innovation Imperative* p.7-8
- 62 See for example Social Care Green Paper (DoH (2009) 'Shaping the Future of Care Together'; Lloyd, J. (2008) 'Funding Long Term Care' Wanless, D. (2006) 'Securing Good Care for Older People: taking a long term view' London, The Kings Fund.
- 63 Lloyd, J. (2008) *Funding Long Term Care* p.7
- 64 An open letter to the *Guardian* from several members of the Learning Disability Coalition reminded the government in July of an expected shortfall in funding of £200m for adults with learning disabilities. See 'Elderly prioritised over people with learning disabilities, say charities' *The Guardian*, 24th July 2009, accessed online at <http://www.guardian.co.uk/society/2009/jul/24/care-green-paper-learning-disabilities>
- 65 Wanless, D. (2006) 'Securing Good Care' p.xxx-xxxi

- 66 A recent JRF report noted that the 'average annual cost of a residential home placement in 2008 was £25,000'. The report also notes that the bar above which many local authorities stop paying for residential care is approximately the same (circa £23,000 for Kent County Council). See Keen, J. & Bell, D. (2009) 'Identifying a Fairer System for Funding Adult Social Care' London, Joseph Rowntree Foundation Viewpoint
- 67 See Joseph Rowntree Foundation (2006) Meeting the Costs of Continuing Care York, Joseph Rowntree Foundation This report proposed a 1.5% rise in class 1 NI contributions. Here the contrast between the value we place on continuing health versus social care is most evident.
- 68 Robert Shiller has also proposed a form of livelihoods insurance that fulfils this purpose. For a summary of similar approaches, see Kippin, H. (2009) Anglo-Flexicurity: insuring against unemployment in the UK London, Social Market Foundation
- 69 Counsel and Care (2008) 'Lifelong'
- 70 Speech delivered by Phil Hope MP, Minister of State for Care Services, 18th March 2009 at the Progress on Personalisation Conference: 'Putting People First: One Year On'. Accessed online at: http://www.dh.gov.uk/en/News/Speeches/DH_096954
- 71 ACEVO Commission on Personalisation (2009) 'Making it Personal: a social market revolution' London, ACEVO p.12
- 72 One example of this might be the very muted reaction to Ian Duncan Smith's recent proposals on reform of the benefit system – well received and well researched, but with a considerable up-front price tag. To access the report 'Dynamic Benefits: towards welfare that works', see <http://www.centreforsocialjustice.org.uk/default.asp?pageRef=266>
- 73 Thanks to Hilary Cottam for these ideas.
- 74 New (unpublished) research carried out for the 2020 Public Services Trust by Ipsos Mori finds that 'fairness' is a 'near universal' priority for citizens.
- 75 Keen, J. & Bell, D. (2009) 'Identifying a Fairer System' p.9

