

Health and Social Care Funding

The UK government's approach to meeting the health and welfare needs of older people has generally been and continues to be, highly contentious. The shifting boundaries between health and social care health services were often the driving force behind changes in local authority residential care. In the 1971-93 period specifically, there was constant tension over 'what is health care?' and 'what is social care?', with the fear on the part of social services that health was pushing more and more responsibilities for older people their way without any significant transfer of resources. It is then hard to avoid the conclusion that one of the main drivers of community care policy for older people at a local level was the need for social services authorities to respond to major changes in health care provision. At this time the NHS embarked upon significant reductions in long stay hospital beds for older people, resulting in increasingly dependent residents in local authority residential care. The shift was also speeded up from the mid-1980s onwards by the growth in independent sector nursing home care. Another crucial factor was the lack of priority given by central government to long-term health care as opposed to acute care, combined with the national shortage of consultant geriatricians and psychogeriatricians.

One group of older people who have always been likely to generate tensions between health and social services are older people with dementia (1). During the period 1971 to 1993, one of the major challenges facing health and social services remained how to develop coherent services for this group, who were often still referred to as the elderly mentally infirm (EMI) and about whom there was considerable concern in respect of the public expenditure implications of their rapidly rising numbers. Long stay hospital closures often involved older people with dementia, and one of the biggest conflicts between health and social care was over respective responsibilities for this group. As a consequence, there was a growing numbers of older people with dementia in local authority residential care. One response was to use joint care planning and joint finance to develop both institution and home-based services for this group. Nevertheless, in 1993, dementia care services often remained either an area of conflict between health and social services or an area where provision was of poor quality and low priority with difficulties faced in throwing off the legacy of the past.

The restructuring of welfare provision in the 1980s and early 1990s was based on a critique of the inefficiency and ineffectiveness of the previous provision with its heavy reliance upon the state as both purchaser and provider of services. With regard to community care, a series of reports (for example (2)) provided ammunition for those calling for a radical overhaul of provision. Key difficulties exposed included the lack of responsiveness on the part of local authority services, failures of joint working between health and social services and the mushrooming cost of paying for people to live in independent sector residential and nursing homes through the social security budget.

The main response of the government at the time to the critique by the Audit Commission was to establish a review of community care chaired by Griffiths. (3) Four main themes dominated the report:

- that for thirty years central government had failed to develop any link between the objectives of community care policy and the resources made available to meet those objectives;
- that responsibilities at the local level were unclear between health authorities, social services authorities, housing authorities, the voluntary sector and the private sector, and coordination was not well developed;
- that choice and efficiency should be stimulated through a mixed economy approach in which the public, private and voluntary sectors competed to provide services on an equal footing;
- that the system of subsidising private and voluntary sector residential and nursing home places through the social security system was wasteful because of the lack of assessment of need for residential care.

A key recommendation was that social services authorities should be the lead agency for all the main community care groups including older people because such authorities are grounded in the community and accountable to democratically elected councillors. However, social services were not being asked to dominate service provision, but rather to continue to develop a mixed economy of provision. Funding and assessment for independent sector residential and nursing home care were to be transformed. Through assessment by care managers, social services would explore with the client whether or not community based or institutional care was the best option. For those who entered a residential or nursing home after this process, social services would meet their care costs subject to a means test. A transfer of social security monies to social services would enable this to happen and those monies would effectively

have an annual limit for each local authority so that the public expenditure bill for such care would cease to rise in the dramatic fashion of the past.

The Conservative government at the time made no formal response to the Griffiths Report, but many felt it was dismayed by its emphasis on the pivotal role of local authorities. However, it was difficult for the government to generate alternative organisational arrangements such but there was an urgent need to control social security expenditure on private residential and nursing home care. As a result, their White Paper (4) broadly followed the Griffiths recommendations and endorsed his vision of social services authorities "as arrangers and purchasers of care services. This was seen as involving three main roles:

- carrying out an appropriate assessment of an individual's need for social care (including residential and nursing home care) and in collaboration as necessary with medical, nursing and other caring agencies, before deciding what services should be provided;
- designing packages of services tailored to meet the assessed needs of individuals and their carers. The appointment of a 'case manager' could facilitate this;
- securing the delivery of services, not simply by acting as direct providers, but by developing a purchasing and contracting role to become "enabling authorities" .

In addition, the White Paper confirmed a new funding structure for independent sector residential and nursing homes, with local authorities becoming responsible for financing the care support of people in such homes over and above their entitlement to general social security benefits. Reactions to the White Paper were less favourable, it was seen as an expedient way to cap social security payments, perceived very much in terms of the 'marketisation' of welfare and as the starting point for a greater reliance on charging and self-provisioning than had been the case before. However, what did come across is the extent to which resources were stretched, especially in terms of the availability of qualified social workers and experienced managers, combined with the enormous challenge of blending the different components that needed to be brought together.

The Conservative Party lost the 1997 election and hence their pursuit of ever more privatised and market oriented forms of welfare provision were called into question. Although the Labour Party fought the election with the slogan of the 'Third Way', it was not immediately apparent what the implications of this were to be for the welfare state in general or community care in particular. The Labour government initially appeared to have a modest programme of welfare reforms (5), but this proved to be far from the case because of a modernisation agenda every bit as complex and far reaching as the privatisation and market reforms of Conservative governments during the 1980s and 1990s.

The White Paper, Modernising social services (6), argued that the response of Conservative governments had been the privatisation of care provision, which threatened a fragmentation of key services. What was needed was a "third way for social care" which "moves the focus away from who provides the care, and places it firmly on the quality of services experienced by individuals and their carers and families". What was this to mean in practice? The White Paper identified six key reasons why modernisation was essential, One of which was 'Coordination', ie older people are left in hospital - so-called 'bedblockers' - while different authorities argue about who should pay for care. The system did not work together well enough to meet people's needs. This modernisation agenda had a major impact on the availability of health and social care services for older people. It is also clear that community care for older people was a critical policy issue, as can be seen in the government response (7) to the far-reaching recommendations of the Royal Commission on Long-Term Care (8). The debate reflected the public expenditure implications of an ageing society and continuing concerns about the role of the state in meeting the health and social care needs of frail elders.

Labour manifesto commitments relating to community care were limited, but included a Royal Commission to establish a fair system for funding long-term care. However this needed to be tempered by the fact that the two biggest manifesto commitments of all were not to raise the basic rate of income tax and not to exceed the public expenditure plans of the previous administration for the next two years. Although these financial restrictions proved to be as limiting as feared, it did not stop a wide range of policy documents being published, which set out a radical reform agenda for the welfare state. In addition, the end of the two year public expenditure limit saw the Labour government in a position to invest considerable extra public expenditure on health and welfare services. From April 2002, a new system of

standards for long-term care was brought in as a result of the 2000 Care Standards Act, which covers issues such as accommodation choice, access to health and social care, staffing levels, complaints systems and the availability of social activities.

However, the highest profile manifesto commitment was without doubt the establishment of a Royal Commission on the funding of long-term care. Its remit was:

... to examine the short and long term options for a sustainable system of funding of Long Term Care for elderly people, both in their own homes and in other settings, and within 12 months, to recommend how and in what circumstances the cost of such care should be apportioned between public funds and individuals. (8)

The decision to establish such a Commission reflected growing criticism of how the capital resources (and especially the home equity) of older people was being consumed in the last few years of life through expenditure on nursing and residential care home fees. Commission members were unable to agree unanimously on the best way forward and so it was necessary to publish the main report with a note of dissent signed by two of the members. The main report argued that no logical distinction could be made between health care and social care, and between those services that should be means-tested and those that should be free. This was because older people need long-term care not simply just because they are old, but because their health has been undermined by a disabling disease such as Alzheimer's disease, other forms of dementia or a stroke. As yet these diseases cannot effectively be cured by medical care, but people suffering from them will require ongoing therapeutic or personal care of different kinds in order to enable them to live with the disease. In this regard, the only difference between cancer and Alzheimer's Disease is the limitation of medical science. This led the majority of the Commission to conclude that there was a need for a common system for funding personal care that would therefore no longer require a distinction to be made between nursing care and social support (see Figure 2.1 in (8)). The chosen system was to be free at the point of consumption for service users and paid for through general taxation. Although the public expenditure costs of the proposed changes were considerable (see Table 2.1 in (8)), the main report argued that they were perfectly affordable.

The Proposed Definitions of personal care were as follows, personal care would cover all direct care related to:

- personal toilet (washing, bathing, skincare, personal presentation, dressing and undressing);
- eating and drinking (as opposed to obtaining and preparing food and drink);
- managing urinary and bowel functions (including maintaining continence and managing incontinence);
- managing problems associated with immobility;
- management of prescribed treatment (for example, administration and monitoring medication);
- behaviour management and ensuring personal safety (for example, minimising stress and risk for those with cognitive impairment).

Personal care also included the associated teaching, enabling, psychological support from a knowledgeable and skilled professional, and assistance with cognitive functions (for example, reminding, for those with dementia) that are needed either to enable a person to do these things for themselves or to enable a relative to do them for him/her.

Two signatories of the note of dissent were not convinced by such arguments. Not only would a reliance on general taxation mean a transfer from the private to the public purse, but "this huge addition to the burden on public expenditure would not, however, increase spending on services for elderly people by a single penny". This proved to be the view of the Labour government. It decided that the nursing care element of personal care in nursing homes should become free, but social care in nursing homes, residential care and the community would remain open to means testing and charging. This rejection of the majority view of the Royal Commission was justified on the grounds that "actioning the proposal would absorb huge and increasing sums of money without using any of it to increase the range and quality of care available to older people" (7). The labour government rejected the main proposal of the Sutherland report that all personal care should be free and justified the decision in terms of the need to invest in new services rather than subsidise old ones. The most likely reason for this rejection was that NHS care is free whilst social care can be means tested and charged for. The government also justified its rejection of the majority view of the Royal Commission on the grounds that it did not fit in with its radical modernisation agenda.

There is a growing amount of literature on what the Labour government had chosen to call the **Third Way** in public policy, and the extent to which it represents an innovative radical new approach (rather than a subtle way of continuing privatisation and the withdrawal of the state in a form) and acceptable to most members of the Labour Party. So, if New Labour opposed the new Right way, as well as the old Left way, then the third way could promote wealth creation and social justice, it could embrace private enterprise but not automatically favour market solutions; it could endorse a positive role for the state but need not assume that governments provide public services directly.

Under New Labour, policy with regard to health and social care for older adults was described initially in terms of 'modernisation', with more recent policy emphasising the importance of 'personalisation'. As with the concept of a 'third way', these descriptions imply something potentially distinctive to previous approaches – but are nevertheless difficult to define precisely in a meaningful way. However, there were five main themes and issues from the New Labour:-

1. *Funding*: with significant funding increases in the NHS and (although to a lesser extent) in social care, the early twenty-first century was a time of relative plenty for community care.

2. *Long-term care*: New Labour's 1997 manifesto promised a Royal Commission on Long Term Care, which reported in 1999. Although the Commission's central recommendation (free personal care) was implemented in Scotland, it was rejected by Whitehall essentially on the grounds of cost.

3. *The social care infrastructure*: in an attempt to raise the profile and improve the quality of social care, New Labour established a series of new quangoes. A previous organisation – the Commission for Social Care Inspection – was merged with other health care regulators to create a new inspectorate – the Care Quality Commission – in 2009.

4. *Personalisation*: as part of the *Putting People First* vision, New Labour committed to transforming adult social care through support for all.

5. *Specific policy commitments*: support for a range of previously marginalised user groups received additional emphasis via a series of national strategies and frameworks. Particularly important was the growing recognition that mainstream health services had tended to focus too heavily on hospital care for people in crisis and the subsequent need to rebalance the system in favour of providing ongoing support to the growing number of people with multiple long-term conditions, particularly those with dementia.

Long term care became even more important in early 2010 when the funding of long-term care suddenly re-emerged as a key electoral issue. In many ways, much of the furore was caused by a speech given by Gordon Brown at the 2009 Labour Party conference which surprised virtually all commentators by announcing plans for free personal care at home for those with the greatest needs. There were significant doubts that the proposals had been fully costed and thought through before being announced. Indeed, the policy concerned was so out of the blue that it was widely interpreted as an early attempt to make long-term care a key political issue in the run-up to a general election.

In a House of Commons Debate, 14 July 2009, Andrew Lansley (Conservative) made it clear that a system was needed whereby people can be sure that their care needs are supported, a system that raises the quality of care provided in people's homes as well as in residential and nursing care, reverses the decline in productivity in the social care sector, and ends the scandal of people being forced to sell their home or lose their lifetime savings simply because they are unfortunate enough to need long-term care. We will build a system that guarantees our older citizens the care and dignity they deserve. Once in power, a key task for the Conservative government was to make clear the underlying aims of their community care policy and the value base on which they intended to operate.

The coalition Government embarked on an ambitious and widespread reform programme following the 2010 general election. The centerpiece of the reforms, the Health and Social Care Act 2012, introduced substantial changes to the way the NHS in England is organised, whilst work was also underway to improve the quality of social care and reform its funding. The Health and Social Care Bill was preceded by the White Paper (9) which stated that the Department will establish a commission on the funding of long-term care and support, to report within a year..... *'We understand the urgency of reforming the system of funding social care. The Commission will consider a range of ideas, including both a voluntary insurance scheme and a partnership scheme. As a key component of a lasting settlement for the social care system, we will reform and consolidate the law underpinning adult social care, working with the Law Commission. The Government will bring together the conclusions of the Law Commission and the Commission on funding of long-term care, along with our vision, into a White Paper in 2011, with a view to introducing legislation in the second session of this*

*Parliament to establish a sustainable legal and financial framework for adult social care'.....*The real point here was the scandal that 30-40,000 people every year were having to sell their houses to pay for care costs, the current system basically penalising the thrifty whilst the State picks up the bill of those with no assets.

Launched on 20 July 2010, the Commission on Funding of Care and Support was an independent body tasked by Government with reviewing the funding system for care and support in England, headed by Andrew Dilnot, to find a way to create an affordable and sustainable funding system. In July 2011, the Dilnot Commission produced their report Funding for Care and Support. The Commission proposed a new system on support funding where means-tested support was extended but with a cap on the lifetime care costs that every individual can expect to pay. Under their system, everybody who got free support from the state would continue to do so and everybody else would be better off. The Commission viewed the current system as confusing and unfair. It identified the central problem in how people pay for their care and support as a failure of the insurance market, which leaves people facing a potentially catastrophic financial risk against which they cannot insure themselves. In July 2012 the Care and Support white paper was published together with a draft progress report on funding reform.

As a result of the changes contained in the Health and Social Care Act 2012, the NHS is implemented one of the most radical reorganisations in its history. These changes were dominated by the abolition of old organisations such as primary care trusts and strategic health authorities, and the creation of new structures such as clinical commissioning groups and health and wellbeing boards. However, the reforms embedded in the Health and Social Care Act 2012 fail to address the longer-term underlying trends and pressures affecting health and social care services. This is due to the fact that these reforms are mainly concerned with how the NHS is organised, rather than how care is delivered. Although many improvements in quality and outcomes that have occurred in recent years, the ageing population and increased prevalence of long-term conditions require a sea change in thinking and action that goes well beyond arguments about how to improve the performance of the existing system. The current reliance on care in hospitals and residential settings is increasingly and rightly under question, as are traditional relationships between health and social care professionals and service users.

Against the backdrop of concerns about the implications of an ageing population for the affordability of long-term care, the coalition Government announced new measures in February 2013 for funding care (10) to ensure that the elderly and those with disabilities get the care they need without facing 'unlimited costs'. The new measures, which would only be implemented from April 2017 **depending on the outcome of the 2015 general election**, are loosely based on the Dilnot principles and recommendations. However, in the 2013 Budget, George Osborne formalised the government's commitment to introduce a cap on social care costs one year earlier than originally planned, 2016 instead of 2017. The cap will be £72,000 and the means test threshold £118,000. To describe this as a 'cap' however is misleading since the payment does not include the 'hotel costs' (ie board and lodging) nor any excess in home fees above what a local authority would pay. So in reality it will take people 4 or more years before they hit the 'cap'; the vast majority of people in residential homes would have passed away before that happens. Those who stay in care longer than average are potentially in line for state support. Expectations are that it will help just 10% of those needing care. The expectation is that the government will need to find another £1 billion to fund the reform.

However, that is not the end of the story. In 2013, the Kings Fund set up an **independent** enquiry to assess whether the post war settlement, which established separate systems for health and social care, remains fit for purpose. The challenges facing health and social care are significant and urgent. The commission asked whether the post-war settlement – which established the NHS as a universal service, free at the point of use and social care as a separately funded, means-tested service – remains fit for purpose. It explored whether, and if so how, the settlement should be re-shaped by bringing the NHS and social care system closer together. It also asked:

Does the boundary between health and social care need to be redrawn? If so, where and how? What other ways of defining health and social care needs could be more relevant?

Should the entitlements and criteria used to decide who can access care be aligned? If so, who should be entitled to what and on what grounds?

Should health and social care funding be brought together? If so, at what level (ie, local or national) and in what ways? What is the balance between the individual and the state in funding services?

The commission's report (15) is intended to inform the debate on the sustainability of the current NHS and social care funding models and ensure that questions about funding are addressed alongside analysis of how best to meet the needs of 21st-century patients and service users. It was published in time to influence the party manifestos and inform the incoming government's agenda at the start of the next Parliament. Various reviews of the management and funding of health and social care have been conducted in recent years. What set this commission apart from other reviews past and present is that it fundamentally re-examined the terms of the post-war settlement under which the NHS and social care systems remain separate, with different entitlements, funding and legal frameworks.

Andy Burnham for Labour has set out an ambitious and wide-ranging vision for integrated health and social care. It throws down the gauntlet to the other parties to set out their plans ahead of the general election. This echoes the prescription for a single budget and single commissioner for health and social care (15). The elephant in the room is how this will be paid for. Labour has not yet committed to finding the additional £8 billion identified in the NHS five year forward view as being needed to close the NHS funding gap by 2020. While Burnham's plans to improve social care will come with a hefty price tag, Labour will need to balance this with its commitment to reduce the deficit.

Why social care matters

Spending constraints on social care have led local authorities to tighten eligibility criteria, and this has resulted in an increase in unmet need. Nowhere is the need for fundamental change more apparent than in social care where arrangements rooted in the 1940s have not kept pace with the social and demographic changes described earlier in this paper. The King's Fund has argued that a more sustainable model of funding social care is required, and this should be based on a partnership funding model involving both public and private payers (11). However, reform of funding alone is not sufficient and should be accompanied by reform to the system of delivery, including a more integrated approach to the way social care and the NHS are commissioned and provided. A major development over the past 30 years has been the increased role of the independent sector. There has been a progressive shift from care provided in the NHS, free at the point of use, to care becoming the responsibility of local authorities and subject to means-testing. In turn, many local authorities have outsourced their own services to external providers, and almost 90 per cent of social care services are now provided by private and third-sector organisations.

Rapid growth in the numbers of frail older people and younger people with disabilities has outstripped increased funding. A growing gap between needs and resources has led to a tighter rationing of care by local authorities, with 85 per cent restricting publicly funded care to those with substantial and/or critical needs (12). Social care resources are being directed towards high acuity and relatively expensive services, despite promising evidence of earlier interventions securing better outcomes in the long run (13). The net result of these trends is that the publicly funded system was more narrowly focused on those with the highest needs and lowest means. The numbers using these services are falling, with more people responsible for making their own private arrangements, often without adequate advice, information or support. In many parts of England, the private economy of care is already bigger than the publicly funded system, meaning that the default trajectory of the current system is towards one in which most people will be responsible for arranging and funding their own care in a private market. There are concerns also about the quality of care that is offered both within residential care homes and in people's own homes. Regulation by the Care Quality Commission provides some safeguards against poor quality, but doubts remain about the ability of regulators to prevent well-publicised failures in the care of older people in residential settings, in part fuelled by concerns about a shift towards greater self-assessment by providers and fewer formal inspections.

The separation between health and social care established in the post-war period is increasingly hampering the delivery of the seamless services that these people require as they move between different settings and their needs change. Areas of England that have found ways of overcoming this separation are reaping the benefits in terms of reduced use of acute hospitals and care homes (14).

There are 1.3 million adults receiving publicly-funded social care services in England, and they include some of the people with the most complex needs in our society, for example, the oldest of the old, people with cognitive impairments and numbers are set to increase over the next years and decades, as life expectancy continues to rise. These exert an upwards force on the demand for social care. The scale and significance of social care as a policy area is

therefore undisputed, and yet it receives comparatively little attention in everyday public and political debate. This may be due to social care being the responsibility of local rather than national government, delivered by a large number of organisations without a unifying 'brand' (unlike the NHS), and the fact that entitlement is means-tested (in England, Wales and Northern Ireland but not wholly so in Scotland). This combination deprives social care of a natural lobby. Only those who come into contact with the service – directly or through family members - are likely to become aware of its limitations and inadequacies, and they may be more concerned with dealing with their immediate situation than raising wider issues for debate. Moreover the system itself and the issues involved in reforms are complex, and not easily summarised in a headline or sound bite.

The shifting boundaries between health and social care 1970-1993

The development of welfare services for older people in the 1971-93 period demonstrated how health services were often the driving force behind changes in local authority residential care. This period was one of direction from central government on the need to work together, but also one of considerable organisational change for health. More specifically, there was constant tension over 'what is health care?' and 'what is social care?', with the fear on the part of social services that health was pushing more and more responsibilities for older people their way without any significant transfer of resources. One of the main drivers of community care policy for older people at a local level was the need for social services authorities to respond to major changes in health care provision. More specifically, the NHS embarked upon significant reductions in long stay hospital beds for older people. This resulted in increasingly dependent residents in local authority residential care. The shift was also speeded up from the mid-1980s onwards by the growth in independent sector nursing home care. Another crucial factor was the lack of priority given by central government to long-term health care as opposed to acute care, combined with the national shortage of consultant geriatricians and psychogeriatricians

One group of older people who have always been likely to generate tensions between health and social services are older people with dementia. One of the major challenges facing health and social services remained how to develop coherent services for this group, who were often still referred to as the elderly mentally infirm (EMI) and about whom there was considerable concern in respect of the public expenditure implications of their rapidly rising numbers (Health Advisory Service, 1983). Long stay hospital closures often involved older people with dementia, and one of the biggest conflicts between health and social care was over respective responsibilities for this group. People with dementia often had little medical intervention available or appropriate and so their greatest need was for social support. As a consequence of this, growing numbers of older people with dementia were in local authority residential care. One response was to use joint care planning and joint finance to develop both institution and home-based services for this group. Nevertheless, at the end of the study period dementia care services often remained either an area of conflict between health and social services or an area where provision was of poor quality and low priority.

Boundaries between health and social care continued to shift, but they shifted mainly in one direction. Social services were expected to take on responsibilities for older people who would once have been deemed to lie well outside any definition of "in need of care and attention".(1948 NAAct) Not only this but they were expected to work ever more closely with health over the planning and delivery of services, especially at the community level. The resultant tensions and arguments outlined were perhaps inevitable.

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