SOCIAL CARE FUNDING AND DETERMINING AN APPROPRIATE CAP ON CARE COSTS

The initial thrust of the Conservative Party manifesto proposals to have elderly people with substantial property assets, needing care in their own homes, pay for more of it themselves has merits. It recognises that the state cannot afford to pay for all the burgeoning cost of care in old age, for the growing numbers of people who are living much longer, and that we all need to take more responsibility to save to support ourselves in our old age; also, that it would be unfair, inter-generationally, for the bulk of this extra burden to fall on younger working adults, through paying higher income tax, when many elderly people have been able, fortuitously, in many cases, to accumulate substantial property wealth.

Equally, though, the subsequent recognition that there also still needs to be a move towards social insurance, to be able to limit and manage the costs of care better as a nation, facilitated by establishing a cap on costs facing people individually, must also form part of any balanced and equitable overall, longer term solution.

It is also right that careful consideration needs to be given to the level at which such a cap be set, in the wider context of the funding requirements and other imperatives for more radical restructuring of the way sustainable social care should operate in future, as part of the green paper formulation, after the election.

The financial, economic, market sustainability, social policy and political aspects and implications of establishing a cap are complex and inter-related, and all need to be much better understood, based on detailed analysis, if appropriate decisions ae to be taken within a holistic solution, to address the many challenges facing social care and health care together.

Specifically, this means appreciating, much more realistically, the extent of underlying current underfunding of social care, what is being paid now by those paying for their own care, and what the funding implications are of each element of the proposals, for local authorities, the NHS and those needing to pay for their own care. This needs to be understood in the context of changing demand and supply dynamics, and the market sustainability implications, at a local as well as national level, as the impact will vary considerably around the country. This article highlights some of these important considerations.

Underfunding under-estimated

Firstly, the current public funding shortfall for adult social care is very much understated in the estimates used by the government and will nowhere near be fully addressed by the £2bn outlined for social care in the supplementary 2017 Budget, according to a new paper '*True Cost of Care, Social Care Funding & Market Sustainability*'[i] . If proper allowance is made, in particular, for the underlying shortfall in local authority fees relative to the current true cost of care, in specialist services for younger adults, and funding the increasing levels of unmet needs, then the current shortfall has been re-estimated as around £4bn, rather than the highest previous estimate of £1.9bn, produced by the Local Government Association, for 2016/17. This has a similar knock-on impact on the shortfall estimated by 2020, after allowing for extra funds raised from higher council tax and other sources, of £2.1bn.

The paper re-estimating the funding shortfall also seriously questions whether even the greater level of extra funding it recommends would be sufficient to ensure sustainability of the market, given the need to pay competitive wage rates sufficient to attract, recruit, train and retain anywhere near enough extra nurses and care staff to meet increasing demand. A broad estimate of a potential, 'indicative' further £1bn is thought might be needed to have a much better chance of achieving this.

Market sustainability risks and self-funder fees

Market sustainability risks vary considerably around the country, especially in relation to the care of older people, with much higher risks in areas of generally lower average affluence, where there is a much lower proportion of older people paying for their own care at full rates, to support the continuing viability of care operators. Insufficient additional funding, in any case spread for too long, over the next three years, is therefore unlikely to prevent substantial further closures of care homes and other care services in the short-term.

A major recent study, *'Market Sustainability and the Care Act'*[ii] provided strong evidence that self-funders in care homes for older people are often being asked to pay premium level fees above the cost of care, to cross-subsidise fees paid below the cost of care by local authorities. As provider costs and the shortfall in local authority fees have been exacerbated with the introduction of the national living wage, this has led to further increases in self-funder fees, well above the extra costs of care.

If underfunding leads to shortages in care service capacity then, inevitably, this will also lead to further increases in prices, given the fundamental laws of supply and demand. If individuals receiving social care are to be expected to continue to pay for a large proportion of the care they receive, and possibly, for some, an increased proportion, having to pay at an unnecessarily and unfairly high price is a big issue, which also needs to be addressed as part of any overall solution.

Conservative manifesto implications

Turning to the funding implications of the government's manifesto initial proposals, the increased limit of £100,000 remaining wealth (up from £23,250) above which individuals will need to pay for care will require extra funding. This will affect local authorities disproportionately in areas of lower general affluence, where house prices and assets are low and many more people will need council support.

If this extra funding burden is not quantified and addressed specifically in determining funding requirements, this will restrict fee increases affordable by councils and exacerbate the failure of more care businesses in these high risk areas. Whether individuals will be allowed to make top-up contributions to low council fees, as originally envisaged under the Care Act Part 2, could potentially mitigate any additional fee shortfalls for providers, but only probably very partially.

Offsetting this, including the value of homes in assets when looking at payment for homecare costs would potentially mean many more older people having to pay for homecare costs over time and reduce funding costs for local authorities quite considerably. To the extent that they

pay for their homecare at higher rates, closer to the true costs of care, then this will also help the financial survival of more homecare provider businesses.

Setting the cap

The inclusion of a cap on costs to be paid by individuals will offset the reduction in council funding requirements but, in the absence of knowing at what level the cap will be, and detailed further cost analysis being carried out in different parts of the country, the net impact on adult social care funding requirements is, as yet, unknown. Clearly, the impact of different possible levels at which the cap might be set ought to be considered in the context of understanding how much funding will be made available from all other sources to pay the full, true cost of care. So an iterative process will be required, to balance the contribution of local authorities, the NHS and individuals, both to ensure sufficiency of funding and equity of relative contributions.

This is likely to be more complicated than might be being expected, but lessons should be learnt from analysis conducted in the 'Market Sustainability and the Care Act' study, and new proposals simplified if at all possible, without reducing fairness. Dilnot's original proposal was for a care cap of £35,000, but this was increased to £72,000 by the government, on public funding affordability grounds. Given that care costs relating to accommodation and living expenses (as opposed to support costs) were also excluded in accumulating costs counting towards the cap, this meant that many fewer individuals would ever be likely to reach the increased cap.

It was also recognised that the costs of care in care homes varies very significantly around the country, principally as a result of the enormous variation in the cost of land. As a result, and also taking into account that most people entering care homes for older people are already very frail, and chronically ill in many cases, and most do not survive for more than two years, the study estimated that only around 3% of individuals' care costs would ever reach the cap in more affluent areas of the country, and a miniscule 1% in less affluent parts of the country. So the care cap, as specified, would have been a totally ineffective way of trying to limit the costs of care for individuals.

A key question now is, therefore, whether the new cap can be set at a single level (or possibly at levels which vary around the country) which would overcome these anomalies and provide appropriate limits to what people should be expected to pay for the future. With more people paying for their homecare and this being included in payments towards the new cap, more people are likely to reach the cap than the very few previously, (if the cap was to be set at the £72,000 level, as previously).

The possible need to tailor the level of the cap to differences in care costs around the country should be considered alongside recognition that average wealth also tends to vary similarly, especially given the differences in property values. In fact, the relative levels of self-funder fees charged tend to correlate quite closely with relative property values, and therefore wealth.

It may therefore be possible, by tailoring the cap regionally, to have people reach the cap in similar timeframes across the country, for those in care homes at least. The emphasis for a cap has quite rightly changed from what was perceived by many as protecting peoples' wealth for inheritance purposes and ensuring that one's home did not need to be sold to go into a care

home. Along with the greater recognition that older people need to take some more financial responsibility for their care, if they have the wealth, there is the very helpful government proposal that payment for this greater cost of care to be paid could be deferred and paid from one's estate on death.

The cap should now focus more on protecting people from having to pay for much greater than average care costs, based on the greater length of time for which a relatively small number of older people need expensive support. So the idea of tailoring the cap for different levels of cost in different regions could fit well with this thinking.

Whether accommodation and living costs incurred should now count towards the cap needs further consideration. Although recognising that these costs should more logically be the responsibility of individuals, rather than the state, their significance, as frequently the major part of the total care home cost to be paid for, needs to be borne in mind. There are counter arguments for now including them as counting towards a revised cap, if such a cap is to be more effective in limiting overall care costs payable in practice, and simpler to operate, with the fact of inclusion perhaps being taken account of in setting the cap at a somewhat higher level than otherwise.

Health and social care anomalies – dementia

Setting the cap also begs the question as to whether there ought first to be some more fundamental change to which social care conditions should really be treated similarly to health care, in terms of payment. Many of the arguments have focussed on severe dementia and alzheimer's, which often require just as much support as heart and cancer conditions, costs in relation to which are frequently covered in full through NHS funded continuing healthcare. This is what has led the initial government proposal for the elderly to pay for more of their homecare costs to be referred to by many as the 'dementia tax'.

Re-classifying dementia as eligible for NHS continuing healthcare funding would increase the cost of publicly funded care very significantly and may currently be considered unaffordable, but this would also significantly reduce the need for a cap, in practice, for many people. On the other hand, quite a number of people receiving continuing healthcare could probably afford to pay for it themselves, if their property assets were taken into account, with the opportunity to defer actual payment until after their death.

It might therefore be possible to iron out some of the significant anomalies between health and social care by having more moderate conditions and levels of care self-funded, including some continuing healthcare, (for those above the higher means test thresholds, but perhaps only those with even more significant pension income and/ or wealth). Significant support needs and care costs above these levels would then be more consistently paid for by the state, including dementia.

Formulation of comprehensive green paper solutions

So these considerations and issues are inextricably linked and ought to be addressed as part of a more fundamental, holistic set of solutions, perhaps with some transitional arrangements necessary to move towards a better funded, integrated and sustainable set of proposals for the

longer term future, including social insurance. Setting the cap would also need to take into account how much funding will be made available from all sources to pay the full, true cost of care. This is no small task, particularly given the paucity of data currently available on how some costs vary and how much older people are paying for their own care around the country.

In conclusion, it is right that much more careful consideration be given to how much people need to contribute to their social care costs, including proper consultation and supporting comprehensive analysis. However, this will take some time and needs to be accompanied by similar, urgent further analysis of the true costs of care and how much extra funding is needed to pay for this as it varies around the country, in conjunction with assessment of the different levels of market sustainability risk. There is an urgent need for immediate extra funding, in areas of highest risk.

It will only be by better addressing market sustainability and funding challenges facing local authorities, and the NHS (in relation to continuing healthcare), as well as the risks to ongoing provider financial viability and future investment return requirements, that there will be any chance of providing the increased amounts of high quality care and support which individuals need, and to contribute to paying their fair share for.

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[i] **'True Cost of Care, Social Care Funding and Market Sustainability'**, Better Care Outcomes Ltd. March 2017. The full paper can be downloaded from: www.bettercareoutcomes.co.uk/Papers-and-Reports.html

[ii] '**Market Sustainability and the Care Act'**, for 12 Counties and the County Councils Network. Main Report. LaingBuisson 2015. Obtainable from LaingBuisson at www.laingbuisson.com or 020 7833 9123, though extensive extracts and references are included in the paper above.