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Paying for Elderly Social Care

What Principles? What Aims?

POLITEIA

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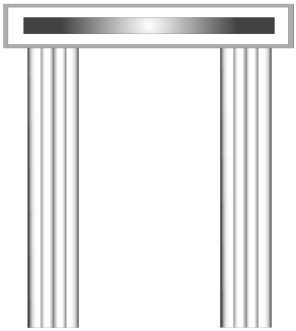

POLITEIA

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Sheila Lawlor*

Overcoming Life's Hurdles

One of the most enduring political questions for this country since the turn of the 20th century has been how policy can best be framed to help people through the unpredictable costs and circumstances thrown up in the course of a lifetime. A dominant aim was to tide people through times of bad luck when, because of unemployment, disability, sickness or premature death earnings stopped, often leaving whole families penniless. Another, contiguous aim was to establish an effective system to pay for retirement when working life and earnings ended. Today a relatively new contingency has been added, how to pay the bill for elderly personal social care.

Popular Principles, Practical Precedents

Many of Britain's schemes from the early decades of the 20th century were woven into a system that built on distinct foundations, reflecting the principles and precedents that were popular and affordable: some continue to shape policy today. These include the contributory principle, maintaining the link between benefit and contribution, and the principle the state should not penalise saving or hard work by a means test. From the early years of the century health and unemployment schemes were based on the contributory principle, later to be extended to other contingencies such as old age. Such schemes remained popular with governments especially until the 1940s and 1950s because they were affordable and as a result, sustainable. They were also popular with people because they guaranteed an important principle, that benefit was an entitlement paid for by the recipient during times of work, to be cashed in when bad luck struck and earnings ceased. It was also seen as important that benefit was paid as a right in return for contribution, not a dole dished out by government officials, subject to arbitrary and bureaucratic conditions or the hated means test. Such founding principles were not only valued by those who paid their way, they were also seen as promoting hard work and thrift:

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people could work hard and earn and save without being penalised by a means-testing state.

These principles found in schemes to replace lost earnings were also the basis for the successful development of the old age pension system in the decades after World War I. The relevant piece of legislation, the Widows, Orphans and Old Age Pension Act 1925, involved a three way contribution paid during earning life by the employee, employer and taxpayer. They were the basis too for Sir William Beveridge's famous 1942 blueprint for a comprehensive social (later 'national') insurance system. He considered the system of social insurance that had developed and flourished in pre-Second World War Britain 'impressive', and that provision to meet need due to lost earnings and other causes was 'on a scale not surpassed and hardly rivalled in any other country of the world'. He proposed bringing together the different schemes and systems in a unified social (later national) insurance system to provide income to replace lost earnings for the most common contingencies. It would be based on the three way contributory principle with benefit dependent on contribution, to be paid at a minimum flat rate subsistence level, with people left with the freedom (and means) to top up with other insurance schemes which a higher contribution could obstruct. It ruled out the means test for contributors, thus respecting the duty and pleasure, as Beveridge saw it, of thrift, of 'saving pennies for the rainy day'. The scheme was premised on three main assumptions, the introduction of family (i.e. children's) allowances, a national health service and ensuring near full employment, interrupted earnings (other than for retirement) being therefore seen as a temporary, insurable risk.

Although governments in later decades watered down much of the earlier thinking about the benefit system in line with the politics of the day, eroded the contributory basis, fudged conditionality and deployed means testing, nonetheless the longer-term aims and principles continued to be adopted and shape other measures in the wider system of social security. Indeed Britain and other countries share what is called a three pillars approach to funding pensions. These three pillars are the state pension, an occupational or workplace pension, both of which build on the three way contributory model, and personal savings, which might include a personal pension. Thus the wider system of social security continues to reflect not only the means popularized in the early century, but the founding principles and aims of its predecessors: to be sustainable, affordable, avoid moral hazard and promote the incentive to save.

Elderly Social Care

These aims and principles have implications for funding the cost of elderly social care. The need is relatively new and expected to grow partly due to demand - greater longevity, helped by advances in medical and diagnostic sciences, mean more people live longer healthier lives often into their 90s - and partly due to changing supply. Changing family structures and economic life have prompted the growth in supply of formal social care: whereas in former decades children or grandchildren might have lent a hand to provide informal care to elderly parents or relatives when needed, today many work miles away. Such trends have prompted social care to shoot to the centre of the policy stage, dominating politics on two occasions recently: during the 2017 general election Conservative proposals for funding care sank like a lead balloon, while this year during the Covid pandemic when high numbers of deaths in care homes dominated the news, the role of the twin health authorities, PHE and NHS England, was in the spotlight. It seems that NHS patients were discharged into care homes, some Covid positive, many untested, and that often elderly residents were not admitted to hospital. Though not the subject of this publication, these developments have lent urgency to demands for rethinking policy about overall responsibility for and funding of elderly social care.

But it would be a mistake to treat social care as one identical gigantic sector that would benefit from a major bureaucratic rationalisation, rather than what it is, a diverse sector dedicated to catering for a variety of needs, in different ways and at different costs. Nor should we forget that most of the c. 8.8 million (8,769,122) people over 70 live at home, some needing a modicum of social care. A small proportion, c. 400,000, live in care homes, a general name used for either residential homes to which people often retire in later life because they need (or may need) some social care, or care homes registered to provide nursing care.

Domiciliary care costs depend on the amount or type of care given to people at home; for care homes, the costs of care are added to the residential costs for bed and board. These costs are paid for by people themselves or paid from public funds - via the local authority, subject to a means test. The legal framework giving local authorities a duty to see that those who need care have it, the Care Act 2014, sets out the arrangements governing eligibility, assessment and support. Today, as a rule, people with assets (of over £23,000 in England and Northern Ireland, £26,000

in Scotland and £39,000 in Wales) are expected to pay the full cost of their care, whether in a care home, domiciliary support, or other types of cares. A rough breakdown suggests that of people in care homes, around 41 per cent fund themselves ('self fund') and 49 per cent receive local authority funding, of whom around a quarter pay top-ups. For those people who have medical conditions and are deemed to need nursing care or medical social care, an NHS 'package' is paid for: NHS-funded nursing care (a weekly payment made to nursing homes by the NHS towards costs of providing residents with nursing care) or NHS continuing care (a package for adults with a 'primary health need' arising from disability, accident or illness).

Many Strands, Different Needs

Elderly social care has therefore many strands and parts. There is no single type of elderly social care, no uniform model for meeting need, no single funding stream. Social care reflects the diversity of need and demand in a modern post-industrial economy. What we see is a diverse system, which provides different types of care in different settings, at different costs - domiciliary, residential and nursing care. While there is scope for focussed, effective reform, there is no good reason to bow to pressure from Whitehall's most senior health bureaucrat to integrate the care sector with the NHS, or to seek rationalise care under a single departmental structure. Bigger is rarely better, as the coronavirus crisis revealed. The NHS, unlike the German health system, was too big and unwieldy. Its command and control system was behind the curve, whether in equipping doctors and nurses working in hospitals, or testing, or tracking, or devising a workable track and trace app. The pandemic revealed that the UK's system has much to learn from Germany's which is devolved, mixed and local. Pressure for change will most probably point in that direction, towards greater devolution and local or individual responsibility, away from the big Whitehall model of departmental fiat.

Indeed, in this analysis, former health minister, Stephen Hammond, discusses how medical/nursing social care could benefit from change, and he proposes a range of solutions, including the possibility of a national independent body, operating like the NHS. He and Melanie Powell, an economist who has a special interest in behavioural economics, highlight the need to secure supply. Each discusses the different options for funding, Hammond from a policy perspective and with a knowledge of the investment and insurance business, and Powell from the

perspective of behavioural theory and economics. Colin Wilson considers the options as an actuary: the questions he poses are not unlike those important since the beginning of social insurance. Is it efficient and does it provide incentives for institutions and individuals, avoiding problems of moral hazard? Will people be better off if they save? Is it sustainable in the longer term?

Social care therefore raises various sorts of questions for policy, many of which have been well rehearsed throughout the 20th century on how best to meet the cost of the unexpected, unpredictable and often expensive contingencies that arise in a lifetime. When in 1942 the Beveridge scheme erupted in a war ravaged, but financially upright, wartime ministry, it catapulted a host of difficult questions onto the political stage, begging a political gesture via instant legislation and a commitment to high spending. The wartime cabinet refused to make promises that might not be realised. International security must come first, along with the need to return the economy to full employment, recovery and trade. There would be no popular win by pledging what could not be paid for. That meant returning the fortunes of their country to prosperity, so people themselves had the means to earn, pay their way, and a state which supported, rather than penalised through high taxation and means testing, the duty, and pleasure, as Beveridge put it, of thrift.

Since then it is no accident that through the twists and turns of political debate, both main parties, once in office, have continued to rely on measures based on the principles on which successful social security evolved in this country, even as they dismembered the earlier ones. They have found that by returning to mixed systems of funding, with contribution in return for entitlement and incentive, and accountability to the user by a mixture of providers, they can best meet need and carry the day fiscally as well as politically.

II
Retirement Income and Old Age Social Care

Colin Wilson*

Much of an actuary's work is concerned with long-term financing and risk. This chapter will consider both retirement income and old-age social care because many of the underlying issues are the same.

Rather than make specific proposals it will consider the wider perspective in order to suggest a framework for approaching the subject, based on three questions:

- What fundamental choices do we need to make as a society?
- What challenges are we likely to face?
- What criteria should we use to judge our choices?

In each case, three subsidiary questions will be considered. The chapter will conclude by asking if this framework suggests where improvements to the current approach can be made.

Retirement income and old-age care are closely connected. They are both ultimately about providing dignity and security in later years.

But there are two significant differences:

First, with pensions we are really only concerned with delivering income to the retired that is adequate, fair and sustainable. It is up to them how they spend the money. But with old-age care *delivery* is also key – are there enough care workers and care home places able to meet people's needs cost-effectively? This chapter focuses on how the cost is met, so it will not consider the supply side further, other than to say that resolving the financing is likely to lead to significant improvements in supply as well, due to reduced uncertainty for suppliers.

Second, everyone needs income in retirement. Some people will need it for longer than others because they live longer, but everyone needs it. Conversely, requirements for old-age care vary significantly between different people in largely unpredictable ways. Mechanisms for pooling individual longevity risk are well-established through Defined Benefit pensions and annuities, but so far we have made limited progress in pooling what we might call 'dependency' risk.

* Colin Wilson is Deputy Government Actuary and a Past President of the Institute and Faculty of Actuaries. He is writing here in a personal capacity.

Fundamental Choices

The first key question of the suggested framework is what fundamental choices do we need to make as a society regarding the financing of systems such as pensions and old-age care? I believe there are three such choices.

The first concerns the appropriate balance of financing ***between*** the generations. In other words, how much should we rely on savings and investment (or deferred consumption in the language of economics) to meet the expected cost, and how much on a pay-as-you-go approach (presumably funded via taxation)? Of course any choice here is bound to be influenced by the starting point. It is unfair to ask a single generation of workers to pay, through taxation, for current pensioners or those needing care, at the same time as being expected to save to meet their own future needs. We currently rely on a mixed approach: pay-as-you-go for the universal state pension, for most public service pensions, and for those needing care who do not have any assets of their own; and savings and investment for private sector pensions (both occupational and personal), and for those needing care who happen to have savings. So in practice we will almost certainly need to continue to rely on a mixture in future. But we might look to change the balance over time, especially as the relative sizes of different generations change.

The second choice concerns a fair distribution of costs and benefits between individuals ***within*** each generation. This is where we need to consider potential cross-subsidies between rich and poor, or fortunate and unfortunate, whether through progressive taxation, differential charging or risk pooling.

And the third choice is about the appropriate distribution of ***risk*** between and across generations. It is worth explicitly separating this from the expected cost, to help ensure we can cope adequately with the ***unexpected***, something which may be particularly relevant in the light of recent events. For example, if the cost of providing pensions to a particular generation turns out to be higher than expected due to unforeseen increases in longevity, should that generation be expected to compensate by accepting lower pensions or should the extra cost be met by others? And who is best able to bear this risk?

Collectively these three choices are about the appropriate balance of costs and risks within and between generations. If we do not agree on what this balance should be, then we are unlikely to agree on the best solutions.

The Challenges

But we also need to consider the challenges we are likely to face - what could go wrong in the future? This is the second key question of the proposed framework. It may help us to consider some of the *current* challenges that have put strains on the pensions and social care systems. Again we can sub-divide this into three subsidiary questions based on different types of factors.

- First, demographic factors. We all know about our aging society. This is largely a function of increasing longevity but also of declining birth rates. Without going into details, what is important is that the dependency ratio – essentially the number of retired people relative to the number of workers - is increasing in ways that were not anticipated when many of the features of our pensions system were first put in place.
- Second, financial factors. Interest rates (and prospective investment returns) have fallen to record low levels - perhaps partly ***because*** of the demographic factors just described - so that advance funding is more expensive. At the same time, investment is riskier because of the need to move to a low carbon economy. And the solvency of many pension scheme sponsors is under pressure as never before.
- Third, societal factors, those arising from changes to society. Recently the nature of working life has been changing for many people, with a tendency to change jobs more often, with less stability of employment and perhaps no fixed hours of work through zero-hours contracts, making it harder to build up a pension entitlement or to make regular savings. And we can expect many more changes as we emerge from the current crisis.

These increasing challenges have made it harder to solve current problems with our pensions and old-age care systems and give pointers to future risks. So how should we set about making the choices referred to above? How can we judge the different options against each other in seeking to make well-informed decisions? This is the third question of the proposed framework.

Judging the Options

While we need to consider how fair we think any solutions are to different groups of people, there are three further questions to consider.

- First, is the system efficient in the shorter term? Are the mechanisms within the system, and the incentives for both individuals and institutions, aligned so the system works as intended and avoids problems of moral hazard or free riders? For example, it is no good setting up a system that relies on those who can afford to save doing so, if they will not actually be any better off if they *do* save.
- Second, is the system financially sustainable in the longer term? Can it handle *expected* demographic and other changes? This is where the projections and modelling of actuaries and others is so important, and the work of the Office for Budget Responsibility (OBR) looking at fiscal sustainability. We need to know there is a plan to cope as anticipated changes emerge.
- And third, is the system resilient over time? Is there flexibility to cope with the *unexpected*? It is not realistic to expect to be able to plan for all possible future contingencies, nor to be able to estimate how likely each possible future is. But it should at least be possible to assess whether everything needs to turn out as expected, and the consequences of a few key sensitivities if it does not.

So how might our current systems be assessed against these criteria and do the results give any pointers as to where to look to make improvements?

Pensions

Let us start with pensions. There seems little doubt that a mix of pre-funding and pay-as-you-go remains appropriate. A great deal of work goes into considering the financial sustainability of individual pension funds and of the system for providing compensation if individual funds fail, through the Pension Protection Fund. Similarly the financial management of both state pensions and public sector pensions includes long-term assessments of affordability, together with some sensitivities.

But what about the risks? Some people have argued that the level of risk associated with defined benefit pensions is now so high that only the government can afford to take it, for example suggesting that government should sell so-called ‘longevity bonds’ to enable pension funds and insurers to reduce their exposure to the risk of people living longer. Conversely, others have argued that public service pensions already constitute a big risk to government finances if future GDP growth turns out to be lower than forecast.

And perhaps there is an even more significant point associated with the fairness of risk. Without going into details, it is clear that risk exposures are very different between those that have fully inflation-protected pensions, those that have fixed pensions and those that must rely on investment performance with Defined Contribution pensions.

This is not necessarily wrong. Many people argue it is fairly reflected in other factors such as salary differentials. But we should ask how sustainable it is. For example, what might be the possible consequences for public order in more extreme scenarios - might such significant differences if they continued bring a risk of not being seen as 'all in it together' in certain circumstances such as high inflation?

Old Age Care

Turning to old-age care, here the problems look more acute. The current system is known to have major incentive problems which discourage saving; it is not set up to cope with the higher number of old people that we know there will be in the future; and we have not yet found an efficient way to pool the risks, meaning that some people will end up incurring significant care costs while others will not.

Rather than make specific proposals at this stage, certain factors can be highlighted.

The framework described here suggests we should look carefully at systems which would incentivise savings, perhaps through some form of co-payment and top-up system; and also provide a means of risk-pooling so that those who do not need so much care themselves end up helping to pay for those who do.

Such risk-pooling might be provided by the private sector, although it may be that there is too much long-term uncertainty for the private sector to do this efficiently. Or it might be provided by government in its role as so-called 'insurer of last resort'. Indeed some might argue that this is exactly the sort of thing the National Insurance scheme was originally set up to do. But of course the current and increasing scale of old-age care costs was not and could not have been foreseen back in 1911 when the first National Insurance Act was introduced.

This highlights the importance of the final question asked as part of the framework above - does the system have sufficient flexibility to cope with the unexpected? We must expect systems to evolve over time as events unfold. We have seen this for example with increases to State Pension age. So it is the key principles that

matter, more than specific fine-tuning. And those key principles should be to ensure that there is an appropriate balance of costs and risks within and between generations.

Whereas everyone will need income in retirement, not everyone will need the same level of old-age care, and people's individual needs will vary significantly and unpredictably. This chapter has focussed on the broader questions to be considered and the principles for effective sustainable systems of funding risk. It argues that progress requires agreement on the appropriate balance of costs and risks between different groups of people. And it suggests pointers for how to make progress in developing a system which is efficient, resilient and involves practical options for how to pool 'dependency' risk.

III
How to Reform Social Care Funding?
An Economic and Behavioural Perspective

Melanie Powell*

The Covid-19 outbreak has refocused attention on the whole area of social care: provision, funding and the relationship between social care and the NHS. The issues are not new. They have been well discussed and policy recommendations abound since the Dilnot (2014) report. The debate about integrating social care and the NHS was recently reviewed by Booth (2019), the case for free social care examined by Quilter-Pinner and Hochlaf (2019), the cost of social care options explored in Bottery et al. (2018) and the eight key issues of this debate clearly summarised by Bottery (2019). What these recent reviews agree on, even before the Covid-19 outbreak, is despite political support, there is a lack of political will to drive through urgently needed change. This chapter reviews the urgency of the need for policy intervention, the standard economic approach that underpins much of past and current policy intervention proposals, and then considers what the perspective of behavioural economics can add to the crisis debate.

Social Care Funding – The current problem

Formal adult social care in England is funded either by local authorities, self-funding or voluntary funding. In 2016-17, local authorities spent £20.4bn on adult social care, compared to an estimated £10.9bn self-funded and £3.2bn voluntary funded, alongside informal care by family and friends of £58.6bn (NAO, 2018). Of the local authority spending, 48 per cent was spent for support in own homes and 52 per cent for long-term care homes (NAO, 2018). The Institute for Government estimate public spending on adult social care has fallen two per cent in real terms since 2009-10 (Atkins et al. 2019).

Recent evidence identifies four main economic factors driving the urgency for reform of social care funding. Firstly, demand for care is estimated to be growing on average by 3.7 per cent per annum compared to projected growth in social care spending of 2.1 per cent (Bottery et al., 2018). Government data shows the factors driving demand are the ageing population over 80 years of age and rising life expectancy generally, the rising dependency ratio, changing household structures and ownership, and a regional clustering of the ageing population in rural areas

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(ONS, 2018). Secondly, the supply of labour into the adult social care sector is limited, evidenced by a high vacancy and turnover rate, with low pay in a high-risk work environment. In addition, the sector relies on a high proportion of workers born abroad (up to 60 per cent in London and 20 per cent elsewhere) many of which may be at risk from policy changes to work visas (Independent Age, 2015). The third factor is the productivity constraint associated with the social care sector. Social care arguably relies on building relationships rather than creating an output that can be separated from the provider. This limits the extent to which spreading care hours over more recipients can be achieved without sacrificing quality (Himmelweit, 2007). If wages rise in the social care sector as a result of labour supply shortage, and this is not matched by productivity increases, the relative cost of social care increases, leading to cost and standard cuts (Dromey and Hochlaf, 2018). Finally, Bottery et al. (2018) estimated a government funding gap for social care of £6bn by 2030-31, before the impact of Covid-19. OBR (2020) estimates suggest UK government borrowing for April to July 2020 alone will be £225bn against the planned annual borrowing of £160bn because of Covid-19, leading to a £200bn increase in the 2020-21 budget deficit.

These budget constraints could limit the funding increases needed to fund reform of social care.

Interpreting Policy Proposals – The standard economic approach

From the perspective of standard microeconomic theory, government policy interventions in social care are identified and justified through market failure theory. Social care is widely considered to be a merit good, often provided in a quasi or public service market. Private market demand underestimates the value of the overall social benefit and too little is provided, leading to government subsidies or some state provision in these markets. Specifically, on the demand side, social care is a complex service good, where quality of service is measured over time. Asymmetric or poor information in the market can limit demand, as users cannot easily judge quality of social care in the short term and have limited potential to switch providers (Dassiou et al. 2015). Buyers may not be users, and where gatekeepers are also suppliers, there may be conflicts of interest. In the UK, the largely private adult social care provision runs alongside NHS health care which is free at the point of demand. Evidence suggests most people wrongly believe social care is also free at the point of demand, limiting the private market for insurance.

(Bottery et al. 2018). So policy interventions such as quality standards regulation, conduct regulation, a redress service, public information, pooled risk via compulsory insurance and health service integration may be justified.

On the supply side, public service markets for social care can result in undersupply and over-pricing where state subsidy and narrow profit margins drive economies of scale, leading to local or regional monopoly or monopsony. Dassidou et al. (2015) argue where the purchaser is a local authority, and the provider is private, local or regional monopoly or monopsony can emerge in social care. The resulting undersupply and overpricing is compounded by high costs of contracting and the provider knowing more than the purchaser about actual quality (Allen, 2013). Regulation could include fee caps, but provider fees will move toward the cap limit (adverse selection) and make it difficult for purchasers to differentiate quality. Whilst regulatory compliance barriers also limit the number of new care providers, the nature of long-term adult care means business failure must be managed. Monopoly providers aware of this, could run inefficiently knowing they can leverage bail outs or subsidies if they fail (moral hazard). Dassidou et al. (2015) suggest more effective prudential and conduct regulation and limiting private provider ownership structure to mutual or charity status may limit the problem in social care. Others such as Dilnot (2011) and Booth (2019) suggest a mix of capped private user fees, pooled risk for public subsidy and integration with the NHS. Allen (2013) argues that the organisational hierarchies inherent in NHS provision are more efficient for providing merit goods such as health and social care, and are more appropriate than public sector markets in achieving political goals to achieve fairness and equity.

Interpreting The Policy Problem - The behavioural approach

The market failure approach of standard microeconomic theory and its justification for policy in social care is based on the assumption that private buyers, purchasers and providers make rational choices, maximising value and using all available information. By contrast, behavioural economics adopts the irrational choice models derived from psychology and Prospect Theory (Kahneman and Tversky, 1979) and has been widely applied to achieve health and social outcomes. When faced with complex decisions like those required in social care choices, even with full information, most people lack the ability or motivation to make a rational choice. Instead, people resort to using short-cuts (heuristics) which lead to

predictable biases, driving choice away from the rational choice outcome. A typical bias affecting health and social care is present bias, where people may want to lose weight or save for future care costs, but consistently procrastinate, as the current benefit of not starting a diet or saving today always appears to outweigh future cost. Another bias is the tendency to revert to the status quo, and do nothing, even though action is planned.

Prospect Theory proposes that people make choices by comparing the apparent gain or loss relative to a 'reference' point such as the status quo or what is salient in people's minds. Choices are seen as either gains or losses (framing), and losses loom larger than similar sized gains (loss aversion) in people's minds. People's perception of the chance these changes might occur are also affected by framing and loss aversion, so that a person's preference for risk can change in any context. The theory predicts that most people will be risk averse in situations where they perceive the risk of a given loss as small (they buy insurance for electrical equipment) and where they perceive the risk of known gains as large (keeping money in an ISA), and risk seeking in situations where they perceive risk of known gains as small (playing the Lottery) and risk of known losses as large (gambling to reduce an existing loss) (Tversky and Kahneman, 1992). These factors mean that behaviour can be influenced or 'nudged' (Thaler and Sunstein, 2008) towards a desired end such as saving for future health care costs, by giving information in a different 'frame', by making a 'reference point' seem more or less salient, altering the apparent risk of gains or losses or making the value of gains or losses clearer.

Research on the impact of behavioural bias on health choices and on how 'nudge' policy can lead to desired health outcomes is now widespread (Holzwarth et al. 2020). Oliver (2019) has recently applied these ideas to the policy debate in social care. Because the behavioural perspective is descriptive rather than normative (as in the case of standard microeconomic theory), the policy analysis depends on the policy maker's desired outcome. Oliver (2019) argues Thaler and Sunstein's (2008) libertarian paternalism policy 'nudges' are acceptable to most policy makers because they preserve free will in personal choice but help individuals achieve what they want by avoiding behavioural bias. For example, this type of 'nudge' would include introducing a default social insurance pension scheme or tax for social care costs with some form of opt out. The default would avoid procrastination bias for those who want to cover their future adult care costs, the status quo reference point and loss aversion (feeling you have lost insurance) will tend to keep people in the

default scheme even though they can opt out (Oliver, 2019). Another example would be an appropriately 'framed' information campaign to raise awareness of individual responsibility and the realistic future cost of social care as proposed by Dilnot (2011). Similarly, Oliver (2019) suggests, including a large lottery prize in a default social insurance tax with opt out to keep people in the scheme, taking advantage of the tendency for people to become more risk seeking with small chances of large known gains.

Coercive paternalism includes situations where policy makers are prepared to accept that some mandatory regulation is essential to ensure individuals can achieve lifetime goals in health and social care (Conly, 2013). From this standpoint, a mandatory social insurance/tax/pension scheme could be seen as a 'shove' rather than a 'nudge' in behavioural analysis, but still acceptable to the majority of policy makers. The policy limits freedom of choice, but is considered necessary to help people avoid present bias and achieve desired outcomes over the long term. Oliver (2019) suggests that a mandatory social insurance tax, subject to a minimum income threshold, whilst based on behavioural theory, would also help to spread risk, thereby reducing market failure associated with the external costs of funding social care. Other examples include the Dilnot (2011) proposal for deferred payments for social care recouped from a house sale, or a similar inheritance tax scheme where social care costs are recouped from an estate after death (Oliver, 2019). Oliver (2013) has also defined a 'budge' as a regulation based on behavioural analysis that improves supplier behaviour and reduces external costs from supply side activity. Examples would be the Dilnot (2011) proposal to establish a single source of supply information in social care for users, and public rankings and performance indicators of care suppliers, which shift suppliers reference points.

This discussion has shown that social care policy has been largely based on the standard microeconomic theory of market failure but that behavioural analysis adds a new layer of understanding to the current crisis. Applying behavioural theory to social care policy not only adds support to many of the existing proposals but also explains why the Dilnot proposals have gained all-party consensus. They are justified by both market failure and behavioural bias theory and are largely acceptable within both the libertarian and coercive paternalistic perspectives of different political parties. Despite apparent political will and all-party agreement on some proposals to resolve the social care funding crisis, policy remains at a

standstill. Whilst the Health Foundation and Kings Fund report (Bottery et al. 2018) argues that 'doing nothing' is not a safe option, behavioural theory suggests that inertia and present bias affect policy makers and to break the policy inertia, we have to debias the policymakers as well as 'nudge' or 'shove' the agents in public service markets (Michaels and Powell, 2016).

Time for Action?

The Covid-19 outbreak has already raised the salience of the value of social care, shifting the 'reference' point of both policy makers and voters, who are now more likely to support mandatory social insurance or tax payments directly linked to social care provision. This makes the implementation of the widely accepted Dilnot proposals politically viable. Taking action now to provide clearer information on the real private future costs of social care would also maintain this salience. Behavioural theory indicates now is the best time for action to break the political inertia and start fixing the social care crisis. Policy does not have to be perfect, it can be reviewed and adjusted after implementation.

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IV
Medical Social Care Post-Covid - A Changing Challenge?

Stephen Hammond*

Supply, Demand and Cost

For many people the coronavirus epidemic brought social care to the forefront of the political mind. The reality is that for the two main political parties over the last two decades it has been to the fore on several occasions. The Labour Party sought to resolve the issues of provision and payment by commissioning Andrew Dilnot to report. The Conservative Party's 2017 manifesto commitments on social care arguably lost it the General Election, a failure which in turn lost the Conservatives their parliamentary majority and led to British politics more generally becoming Brexit paralysed. As a result, the 2019 manifesto commitment to bring forward a Green Paper on Social Care has seemed to fall into the 'too difficult' category with the time scale for publication often announced as 'soon'.

But we should not be held back by the widespread truism that only through either another expert led enquiry or political consensus can progress to a solution be made. The former could take years and might not produce any new ideas. Whilst both the government and opposition are committed to a bi-partisan solution, this would require a seismic shift in currently held positions. For what needs to be solved is little disputed - the scale of needs i.e. demands, the provision, i.e. supply and how to pay to meet need.

ONS data confirms that the UK has an ageing population, the projection is that by 2050 one in four people in the UK will be over 65. The scale of current need and likely future demand can be assessed by considering trends and numbers. Today there are nearly 12 million (11,989,322) people aged 65 and above in the UK of which: 5.4 million people are aged 75+, 1.6 million are aged 85 and approximately 580,000 people are 90. The number of over 65s represent approximately 18 per cent of our population, in comparison in the 1970s that percentage was approximately 12 per cent and it is estimated to be 24 per cent by the middle of the 21st century.

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Medical Social Care – Different arrangements, different needs

For those older people who may need care the broad distinction is between whether domiciliary care or residential accommodation is most appropriate and within residential care one should distinguish between two main types of care. Inevitably the most expensive is what might be defined as Medical Social Care in residential accommodation which provides adult medical and nursing social care for those with specific nursing/medical care needs, or for those discharged from hospital but not able to return to their own homes. A second type might broadly be defined as residential retirement accommodation which essentially provides accommodation for those who can live individually with support within a residential home setting. This support might extend to similar care as might be given to someone frail who remains in their own home or just warden supervision.

This analysis is principally concerned with medical social care and the questions which should now be considered.

Integration and Staffing – Medical social care

First, pressure to integrate social care and the NHS has not changed. Covid has highlighted both social care and the perception that our society's provision of social care should be reformed. For medical social care, the integration of health and social care at an operational level might improve the quality of provision for the individual as well as operational and cost efficiency. The reality is there is little integration and the best examples are NHS units set up to coordinate hospital discharge with local authority provision. A 'de minimis' start to integration would be a whole system approach to delivering care in the most appropriate surrounding. To facilitate this would require the supply of more intermediate medical/social care provision but should allow better utilization of hospital facilities potentially releasing some of the cost to afford it.

When asked to define exactly what operational integration means there is a range of opinions. To create a monolithic structure possibly called The National Health and Social Care Service might seem obvious at first sight. However ever greater centralisation often brings unnecessary bureaucracy, lack of accountability and lack of responsiveness. There might be something to learn from more devolved systems of provision existing in other countries. A national social care body could be established with a relatively streamlined and lean central structure but with control devolved to local trusts with more local autonomy for provision and

funding. These should be aligned geographically with local health and mental health with an obligation for joint working. This might be a better solution but at the very least it is a reasonable question to consider

Integration would be more effective if an understanding of patient needs were comprehensively set out. Therefore, it seems sensible that as people enter the care system a care plan is agreed by all parties. The contents and requirements of the plan would not be dissimilar to that of a child's protection plan as specified by the Children Act 1989. Again, this further, this very de minimis act is the very least that the Green Paper should recommend.

Second, the problem of staffing has not changed, and is unlikely to change. There are significant labour constraints in the social care system caused by the perception of professionalism. Providers in care homes are not accorded the same status of similar occupations in the NHS such as trained nurses and nursing assistants. The transient nature of a large element of the workforce causes supply constraint. Care homes have labour shortages in the summer as some staff migrate to the hotel sector and migrate to the retail sector at Christmas and New Year.

Covid has positively altered the public perception of the dedication and professionalism of social care staff but there remains a status differential. One side effect of NHS/medical social care integration could be to reduce that differential as more nursing staff could be qualified to operate in both sectors. Moreover, with levels of unemployment likely to rise as a result of coronavirus, the care industry should consider a major educational programme working with the FE sector to provide the necessary training of skills to increase domestic recruitment.

It is almost certain that future staffing will still require significant overseas recruitment and preferably greater emphasis on recruiting permanent staff. The Department for Health has already secured an exemption for doctors, nurses and other health professionals from the requirements of the proposed new immigration system. Possible approaches to recruiting more workers internationally without usurping the principles of access based on skill and need, could be explored such as the medical worker exemption; the introduction of a new class of key worker or suspending the income requirement for key workers or defined professions.

Social Care – Changing trends

The cost of future social care will almost certainly rise as a result of Covid-19 and at least three factors will contribute. First, fragility: the social care industry is seen as fragile with many of the private sector providers operating on a perilous financial basis. The care market has had several very large monopolistic providers and a long tail of medium, small and micro companies. It is unclear that this trend will necessarily persist. It is perfectly possible to see new higher cost and higher quality, providers establishing a niche upper end market, alongside a more regulated utility provision for the middle and bottom of the market.

In the last few years the trend has been for several companies to go into liquidation, with changes and the withdrawal of provision even prior to the increased cost pressures Covid has imposed. The impact on the lives of those in care is considerable. So, whatever the structure of residential social care, an important prerequisite will be stability - that it is more stable and can ensure a continuity of care. But increased requirement for the stability of provision is likely to involve a corresponding increase in costs incurred by those businesses.

Second, the role of local authorities. Any analysis of social care should contain an evaluation of the current and future role of local authorities. The Social Care Acts of 2014 and 2015 have placed the primary responsibility for provision upon local authorities. They now assess eligible need and are the one of the largest providers of care, either directly in authority owned homes or more commonly subcontracted by either providing funding alongside self-funded individuals or purchasing care in homes run by companies. Anything up to 60 per cent of local authority expenditure goes on adult and children's social care. If we think that greater integration of health and medical social care is desirable, then whether local authorities are the most appropriate providers must be examined, as must the question of how they should interact with the local NHS. Might a national independent body, operating like the NHS, be a better solution is a reasonable question to consider.

It is likely that the number of coronavirus deaths in care homes during the pandemic will lead to demands for higher quality of care. Of course, there are many reasons why such deaths occurred, and this will be subject to a review when the pandemic subsides. I am not implying that overall quality is poor and indeed the CQC inspections do not suggest that, although the rating system does suggest a large

disparity between the best and the worst providers exists. In future the reality, or indeed the perception, that a 'departure lounge' service is being offered will not be acceptable nor tolerated. This pressure for overall higher quality of both niche and utility provision to rise will not necessarily be based on rational assessment. The judgement will be made by people about to enter care or, even more forcefully, by those who make those decisions on their behalf. There will be demands for more intensive regulation and supervision to ensure our elderly population are better protected. Although these calls for quality may be largely based on perception inevitably a solution will be required. The usual panacea is a demand for a more interventionist regulatory regime. One might reasonably conclude that the role of the CQC, or a successor, will be expanded post coronavirus.

Third, the role of domiciliary care. A further trend I believe almost certain to emerge as a result of Covid-19 is an increased demand for domiciliary care. This crisis exposed the limitations of putting the elderly in care homes an arrangement which initially appeared to be a caring solution. The obvious solutions are either that many families will choose to live in an intergenerational nuclear family or consider how to enable elderly relatives to continue living in their own homes with support for longer. One consequence is likely to be a significant rise in the numbers of people providing voluntary care and a further pressure for more carers with different skills.

Prior to Covid an evaluation of the trajectory of future costs was upward, and rising; so, an assessment of the impact of these three trends will conclude that the trajectory of the curve will be steeper.

Meeting the Costs

No discussion of social care can therefore be complete without some discussion of how we pay for it and who pays for it. Several fundamental challenges and choices must be considered in reaching decision: the question of fairness of burden and benefit within a generation, i.e. sometimes characterised as the feckless versus the responsible and how much the well-off should pay towards the costs of the less well off; the changing demographics of our country and the dependency ratio of those retired versus employed; the intergenerational balance of risk determining the balance between a savings versus a pay as you go approach.

These persist as some of the major challenges, which will be accentuated in a post Covid world, where the younger generations are likely to bear the bulk of the burden of the costs resulting from the Covid crisis. In an era of low interest rates, the incentive to save and make provision for the future may be a low priority. So, the capability and extent of an individual's ability to self-fund will be diminished and given that some people's care is exclusively or partially paid for by the state, a general understanding of the need for some pooling of risk is essential. Inevitably then some combination of general taxation, hypothecated taxation and co-payment models usually features as part of the solution. However, the general rise of asset prices, and house prices over the last forty years in the UK should make the idea of some element of asset related funding plausible. But given the apparent lack of appetite for such approaches, it may now be timely to offer an additional option.

The success of auto enrolment for pensions indicates that social care insurance auto enrolment might provide an attractive solution. The obvious and overwhelming advantage is that the employed person who paid in would be guaranteed a sum of money to provide for their care as and when it was needed. The scheme would need to provide that sums would be ringfenced, portable and jointly funded by an employer to a minimum level. These features would provide the certainty and the security an individual would need to be confident to invest. There are further possible variations which would make auto enrolment even more attractive such as making the individual's guaranteed sum of money were transferrable on death to a partner. Moreover, as the individual payment is automatic there is no question of apathy or inertia preventing provision for future need being made

Three questions nonetheless arise: Is the minimum contribution level likely to be sufficient? How could auto enrolment be made available to the self-employed? What about those already nearing retirement?

If the contribution level is set at a minimum, those with higher incomes or who believe they may have greater need, could contribute beyond the minimum. However, auto enrolment does not provide for the many self-employed, and a solution needs to be found. This could be that a higher contribution level is set for the self-employed, or the employer element of the contribution met by the taxpayer with an element paid by government. Finally, whenever such a scheme where enacted there would be some nearing retirement for whom auto enrolment cannot provide. However, all of these problems can be partially answered by using private insurance to augment the auto enrolment pot.

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Social care for the elderly has been put at the centre of the political stage by the high death rates in care homes during the Covid pandemic. Initially the spotlight was on the NHS, accused of discharging potentially Covid positive hospital patients into care homes without testing. But now more general reform of social care is being demanded, with the NHS potentially cast in the role of saviour.

Successful reform, however, must take account of the sector's diversity. It provides different types of care to meet the different needs of the elderly. Most elderly people continue to live at home; only a minority, under five per cent, live in care homes, some of which are registered to provide the nursing care needed by people with medical conditions.

The questions for policy are therefore straightforward: how to pay for care, and how to promote the diversity of supply. *Paying for Elderly Social Care: What Principles? What Aims?* brings us through a range of possible answers. Stephen Hammond, a former health minister, suggests funding options that include insurance schemes modelled on the workplace pension. Melanie Powell, an economist, considers questions of market failure and behavioural economics. Colin Wilson explains the actuarial principles that provide incentives and avoid moral hazard. Sheila Lawlor, Politeia's Director and an historian, cautions against plans for centralisation under the NHS and points instead to Britain's successful systems developed to pay for life's unpredictable costs.

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