Written evidence submitted by the Adam Smith Institute (HSC0025)

Executive summary:

- Proposals such as raising public care budgets, raising the asset qualification, or making social care free to all will not work on their own. They do not change the fact that the care system itself is dysfunctional, full of perverse incentives, and badly undercapitalised.
- Meanwhile, families are unwilling to save for something that only one in three will need. And insurance is not viable while the 'long-tail' (risk that some individuals may need many years of expensive care) remains.
- To bring about effective change for the long term, policymakers must find solutions to the structural, incentive and supply problems in the system.

Solutions:

- Future sustainability and pressures on public funding, now greatly exacerbated by the Covid-19 pandemic, require new ways of enabling those individuals and families who can make greater provision themselves to do so. This could involve insurance or personal care savings accounts and other options.
- To make insurance viable and affordable to the many, the state should pick up the 'long-tail' costs of those needing many years of care. Involving insurers would also put pressure on providers to restructure and deliver better value for money.
- Local authority-funded care at home focuses on price, not quality. It should instead embrace new providers who have developed better delivery technologies, integration with healthcare, and training and recruitment of carers.

Evaluating the NHS Care option

One of the most commonly heard suggestions is that social care should be rolled into the NHS and, like NHS care, be provided free at the point of use—possibly financed with a new 'care tax'. To some extent, this idea is popular with the public.
It would also allow better integration of healthcare and social services and would remove disincentives and unfairness.

However, the necessary rise in taxes or increased Government borrowing that would ultimately be paid for by the younger generations are less popular. Such a policy was in reality unaffordable even before the costs of Covid-19.

Though much social care is already financed publicly through local authorities or the NHS, most care services are delivered by independent providers. Merging care homes (even those just for persons aged 65 years or over) into the NHS would be the largest nationalisation since the 1940s, landing taxpayers

with a compensation bill to owners as much as £20 billion, plus the additional substantial annual cost of running them.

The NHS, which already has one and a half million staff and is the seventh largest employer in the world, would see its employee numbers swell to over two million, making it even more difficult to manage than it is today. Yet it seems likely that social care would remain, in this new public enterprise, the poor, underprovided relation, alongside mental health care.

The proposal would not solve the fundamental problem that more than 75% of our care homes are old and no longer meet current standards—with narrow corridors and small rooms without en-suite bathrooms and often with insufficient day space. Even to maintain these homes to the present standards would require half a billion pounds of annual maintenance capital expenditure. More than 300,000 beds are increasingly obsolete but remain operative despite not meeting the minimum standards introduced by the last Labour government in 2001. At some point, additional money will have to be found to replace them.

It is questionable whether taxpayers would be willing to underwrite such large sums when only a third of them resort to social care at all. Furthermore, there would be a surge in demand if social care became free to everyone: for example, from the many families who are currently struggling to care for relatives themselves or to pay carers to look after them.

Other options

It would be a mistake, therefore, to alight on the seemingly simple but flawed idea of making social care free at the point of use, as healthcare is. That is particularly true when there are other options, including ones that are already working in other countries.

For example, there is a proposal that taxpayers be allowed to set aside around £100 per a week, tax free, towards social care. This would allow individuals to accumulate enough funds throughout their lifetime to fund social care costs. The funds could be flexibly accrued or deducted and would allow multiple taxpayers to contribute to a family member's care, giving families more freedom and autonomy back to the individual in need of social care services.

Even so, the idea retains the basic unfairness of the current system, because, since there is no widespread pooling of risk, some families will retain their tax-free savings (to pass on to their children) while others will not.

Another option is something like Australia's nationwide aged care subsidies and supplements combined with substantial elements of user contribution. Australia's system provides a similar level of care to all individuals no matter their particular means. All individuals are expected to pay some part of their care. They also receive a minimum level of state funding. Those with lesser means receive greater state support. The Australian system also requires substantial but refund- able bonds to help cover the hotel

costs of care homes (also government funded if an individual has no assets). Unfortunately, it therefore also retains the basic unfairness of the UK system as there is no widespread pooling of risk. On the positive side, it gives families greater security and choice (far more than the current 'top up' arrangements in some regions of this country) and would end the stark divide between those who are fully state funded and those who are forced to pay the full cost of care, easing some of the perverse incentives and unfairness.

The point is that there is a world of options like these, and they all have their up- sides and downsides. But we recommend that the government should at least look into the alternatives before it rushes to adopt solutions that don't actually solve all the challenges and inequities that exist in the current system.

New partnerships

We favour instead a new partnership between insurers, individuals and the state in terms of recapitalising the care home stock and helping people afford long term care more easily. Today, many people would like to pool with others the risk of care costs in future— as they insure against other risks—but they find the products limited and unattractive. There is only a (roughly) one in three chance of them needing the care, so they are tying up money that might not be needed. Also, they do not know how much to save, since they do not know how long their care needs, if any, might last. And there is less point in paying premiums when those who do not might get free care anyway.

Moreover, as we have seen, if insurers are to offer a reasonably attractive product, they cannot remain exposed to the 'long tail' risk—the risk that the insured person may be in a care home for many years.

This is surely an opportunity for a new partnership. If people insured themselves for a defined period of care home care (say, six years) and the government promised to meet the costs beyond that, an insurance solution would become feasible and affordable. If more people were insuring, it would ease pressures on local authority budgets. And insured people could keep more of their own assets to pass on to their families, without the arbitrary spend-down limits imposed by government policy.

An insurance-based system, with the government as the long stop, would also help regularise the self-pay market. Insurers would charge one premium for a whole service, including care and hotel costs. They would insist on having clear contracts with known future costs—so clients would no longer be presented with unexpected cost increases after they had moved in. Insurers would also put a downward pressure on the level of fees, perhaps insisting that clients choose from a list of approved care home providers, just as healthcare insurers do. All in all, that would reduce costs for the government as and when it did have to step in and would very probably drive up standards as well. There is no reason why an insurance product cannot be developed for private home care as well.

Redesigning care at home

Local authority-funded care at home is primarily delivered through independent providers.

At present, care at home is contracted on the basis of hours or number of inputs, with the focus on price rather than outcomes, and with no encouragement to integrate health and social care. This cannot continue in its present state. Local authorities should look in future to contract with the new generation of providers who are waiting to come to the UK, who have developed more sophisticated caregiver recruitment and training plans, and who employ the likes of blockchain and artificial intelligence (AI) in combination with Amazon's personal assistant Alexa and Apple's Siri—all the stuff of real transformational change. The regulator will also need to get up to speed with new technologies and adjust the rules accordingly: old red tape should not be left in place. AI will close many gaps in information and assist where human resources are limited. Significantly lower hospital readmission rates will be a further payback.

Developing insurance products for long term care will also be a catalyst for network building and technology enablement in this sector. We foresee that commissioners who currently know what they are getting elsewhere in terms of quality standards will want the same level of knowledge for the local authority home care sector.

The entry of insurers into the long term care sector would be a further catalyst for change that could enable all payers to have access to systems that demonstrate that all parties are receiving value for money and a quality product.

Rebalancing generational contributions

If more public funding is needed, we must think radically. Over the decades, more and more costs have been shifted away from elderly people and onto younger ones: Attendance Allowances, free TV licences, lower rates of National Insurance for persons over 60 years of age, Winter Fuel Payments—all these and more are costs borne by people of working age.

It would be fairer, and more efficient, to phase out some of these benefits so that older but wealthier people make more of a contribution to their generation's care costs. If it is a government priority to raise the £23,250 threshold significantly from its current level, then increased borrowings, a rise in national insurance (say for persons over 50, and the abolition of NI relief for persons over 60 years) would be an equitable way of funding this.

Conclusion

A more rational and affordable care system will involve disrupting the market. But the result of that disruption, through methods such as insurance and government cost sharing, or pension-fund financing of care home provision, will be greater supply, greater sustainability and greater fairness.

Public sector reforms are part of this: for example (as mentioned), NHS-funded Continuing Care creates perverse incentives and unfairness. Funding rules, too, produce other perverse incentives. If you go into a care home and your spouse is no longer with you, your residence is counted under means testing rules; but if care is delivered at your residence, it is not. Or again, (in another rule introduced by the Cameron government) the home is not included in means testing for care at home, while it is if care is to be provided in a care home. These examples (and others) distort local authorities' decision making.

The debate on social care has centred on how much more of it we can afford, either as individuals or as taxpayers. Sadly, that debate is pointless when the money we spend goes into a system that is largely dysfunctional. But with fresh thinking, it is possible to improve the quality of social care provision, to find ways of making it more affordable, and to rebalance service delivery more rationally between care at home and care in a care home.

An arbitrary boost to care budgets, and minor changes to the existing system will do little good and will not help long term sustainability. What we need are new partnerships in new markets that embrace fundamental change across the board, improved transparency and better integrated health and social care.

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