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Care Funding Reform

Delay or delete?

In a letter to the Local Government Association (LGA) on Friday 17th July, Alistair Burt, minister for social and community care, announced a 4 year delay in implementing section 15 Care Act which provides for individual contributions to their personal care to be capped, with councils paying the full cost thereafter. The plan is now to introduce this on April 1st 2020. Will this ever happen? The author would wager not.

Foundations at risk

The proposal for the capping of care costs emerged from the Dilnot report "Fairer Care Funding", published in July 2011. A central problem to be addressed was that about 1 in 10 residential care recipients would suffer a catastrophic loss of wealth in consequence of health problems encountered in later life. Dilnot argued that this scenario presented an obvious case for a social insurance approach whereby the individual taxpayer had an interest in paying additional taxes to insure themselves against such an eventuality. In the Dilnot scheme, the taxpayer would not cover the full risks. But by limiting the risk, space would be created for private insurance providers to cover the rest.

The estimated cost of that insurance was £6 billion over the 5 years to 2020 and the main beneficiaries of that spending would be the modestly wealthy, mainly home owners with limited liquid capital.

It was always obvious that this philosophy was at odds with austerity which has resulted in substantial cuts in the ability of councils to fund social care for those too poor to afford it.

In its letter to Jeremy Hunt calling for a delay, the LGA states that it has made savings of £3.5 billion in social care since 2010 and that the funding gap in adult social care is growing at £700 million per year. It writes that:

> **"This means considering postponing new costly initiatives - even those which we fully support - if that is the only way we can secure sufficient funding for mainstream social care services. It would be deeply damaging to press ahead with a costly and ambitious reform programme if the very foundations of the system we are reforming cannot be sustained."**

The message is that the needs of the less well off are so great, that social insurance assisting those with assets including a home, is an unaffordable luxury. In the author's view, given the consensus position on taxation policy, the financial strains on the NHS and social care along with the increasing demand caused by an ageing population, it

is very unlikely that it will ever be efficient for government to direct scarce tax revenue towards addressing the financial interests of the middle class. Any capacity for taxation will be directed to meeting basic quality standards for those who cannot buy quality care themselves. The principle of collective insurance of personal risk through taxation that underpins care capping looks like a policy relic from a previous era. The only caveat is that April 1st 2020 is at the start of an election campaign and as we know, pensioners vote.

Although not mentioned in the minister's letter, Community Care, an online social work magazine, reports that the increases in the maximum capital a person may have before being ineligible for financial support will also be delayed until 2020. From 2016 this was due to rise from the current £23250 to £118,000 for home owners and £27,000 for others. For the same reasons, it appears unlikely that the full increase will ever be implemented.

Deprivation disputes likely to continue

The Dilnot approach would have given those with significant liquid and housing assets a stake in the publicly funded social care system. Now they will continue to be unaffected by it as their assets are unlikely ever to fall below £23250. They will continue to have the option of purchasing good quality care.

Now exposed to unlimited risk, those with more modest assets will continue to be interested in preserving them for their children. The Care Act gives councils extended powers to recover assets where they reasonably believe that care fees avoidance has taken place. But there is a substantial risk that the families of those who have made gifts entirely innocently will be dragged into this process. Councils may now send the bill for care to the recipient of an asset where they can draw a reasonable inference that a significant and operative purpose of the transfer was to avoid paying care fees, regardless of when that transfer took place. Under the pre Act legislation, that power was restricted to transfers occurring in the 6 months before supported residential began.

Councils have an obvious conflict of interest when making these determinations. It is the experience of Wrigleys community care team that councils have little incentive to mount a proper investigation into care fees avoidance allegations because the quality of evidence required of them in reaching a deprivation decision is so low. A more in depth investigation can only either confirm the council's suspicion or exonerate the resident and is a cost to the council in terms of staff time and potentially lost fees. Moreover it is not the practice of most councils to suggest that people in this position get independent legal advice.

The Department of Health has been developing proposals for the independent appeals system to be implemented under section 72 Care Act. This might have provided independent redress. But that appeals system looked set to exclude deprivation and other means testing decisions, focussing on assessment and care planning. But in any event this too has now been delayed pending consideration of how if at all, to fund it.

What's left of the reforms?

Research by Wrigleys has indicated that the information duty under section 4 of the Act has not yet translated into an increase in the information offer beyond what was previously available, with many councils satisfying this duty by referring residents to already existing information services.

The requirement under that section to identify and refer residents who may be in need of financial advice is similarly undeveloped. However this provision was made in the expectation that the financial services industry would develop products to provide private funding for care. As the Minister writes "there are no indications the private insurance market will develop as expected." The absence of a care cap combined with uncertainty over policy direction will continue to obstruct the development of that market.

The government has also postponed until 2020, implementation of the duty upon councils to arrange care for self funders. As reported in an earlier newsletter, the concern was that this would force councils to raise their funding of care homes because care homes would no longer be able to charge a premium to self funders to cross subsidise uneconomic council placements – a practice that was the only thing keeping some providers in business.

The deferred payments regime which is a sort of mortgage for care payments in residential care, has been implemented replacing a scheme that was free with one that charges interest and an arrangement fee, but with mandatory availability. The apparent incentive not to sell your house which was the consequence of the higher capital limit for home owners is likely to reduce demand for deferred payments, but also free up housing stock for a younger generation of buyers.

Implementation of the provision to allow residents to top up from their own resources now looks questionable if capital limits will not increase as proposed.

The duty to promote the integration of health and social care under

section 3 of the Care Act will doubtless lead to some sensible reduction in the well recognised fragmentation caused by the health and social care divide. But tensions around responsibility for funding residents, in particular eligibility for NHS continuing care, look set to remain now that exposure to means testing is indefinite.

We are left primarily with a rationalisation of the process of assessment and care planning along with a focus on prevention. The establishment of an overarching well being duty is an important development finally identifying a mission statement for social services departments around which they can understand their role (which has been at risk of blurring into a low level medical service in support of the NHS) and build delivery.

Mr Dilnot can at least take comfort that his recommendation for national eligibility criteria for care has been implemented to resolve the problems of inconsistent provision geographically, although this has little effect on the residential care sector.

A time of consolidation

The ambitious White Paper of July 2012 was titled "Caring For Our Future." The change of tack may be summarised as "Focussing on the Present."

The LGA has called for the money that would have been spent on care capping to be recycled back into the existing care system. It remains to be seen to what extent that occurs. An additional £6 billion might just allow the market shaping duty under section 5 of the Act to work in practice (see newsletter 7). But of course if that £6 billion is used to bolster the existing service, an additional £6 billion will need to be found to implement care capping in 2020. This does not seem likely.

As the minister conceded in agreeing with the LGA, delay was the only realistic option in practice given the government's wider policy framework. But the overall meaning is that for the foreseeable future, to use the minister's phrase, we are in "a time of consolidation". Change in social care will be incremental, at minimal cost, and publicly funded care will continue to be a safety net service for those otherwise unable to afford it.

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