

# RCN Policy Unit

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# **Wanless Social Care Review: Securing Good Care for Older People: Taking a Long-term View**

### ABSTRACT

The Wanless Social Care Review "securing good care for older people- taking a long term view" is the first time that a comprehensive analysis of a complex area of funding care outside the NHS. This Review complements those that Sir Derek Wanless has been commissioned to produce on NHS funding. This Review was commissioned by the Kings Fund and published in March 2006. It identifies the financial and other resources needed so that comprehensive, high quality care is provided and how this might be funded. This Briefing sets out the main recommendations of the Review and highlights the particular areas of concern that were raised.

April 2006

# Introduction

The Wanless Review in social care was commissioned by the Kings Fund and published in March 2006.

The terms of reference for the Review were:

- To examine the demographic, economic, social, health and other relevant trends over the next 20 years that are likely to affect the demand for and nature of social care for older people (aged 65 and over) in England (Part 1)
- In the light of this, to identify the financial and other resources required to ensure that older people who need social care are able to secure comprehensive, high quality care that reflects the preferences of individuals receiving care (Part 2)
- To consider how such social care might be funded, bearing in mind the King's Fund's commitment to social justice (Part 3)

The King's Fund Review seeks to determine how much should be spent on social care for older people in England over the next 20 years, to assess what funding arrangements need to be in place to ensure this money is available and supports high quality outcomes, and to hope the results will make a significant contribution to the debate on the future of social care.

This paper sets out the main recommendations of the Review and highlights the particular areas of concern that were raised in the main discussion.

## The Review

The Review is split into the following three parts and relevant chapters:

### **Part 1: Evidence and Trends**

1. Origins and development of social care
2. Patterns of need for social care
3. How is the current system performing on services?
4. How is the current system performing on standards and processes?
5. How is the current system performing on outcomes?

6. Who pays what?
7. Workforce
8. Informal care
9. New influences on care

### **Part 2: Resource Requirements**

10. The outcomes needed in 2026?

### **Part 3: Funding Options**

11. How should social care funding systems be judged?
12. Changing the way the system is funded.
13. Assessing the funding options: implications from the model
14. Discussion and recommendations

## Part 1: Evidence and Trends

Chapters 1-9 assess the state of social care today. It examines the quality of care provided and current cost and funding arrangements. It considers the implications for the workforce, the substantial contribution of informal care, and an assessment of emerging new models for providing care.

There is a move towards supporting people in their own homes rather than viewing care homes as an inevitable destination for the very old. Over the past 15 years, local authorities have scaled back in-house provision in favour of independent providers. There is an emerging emphasis on prevention and rehabilitation which aims to reduce demand for high intensity services.

The population is ageing but increases in healthy life expectancy have not kept pace with improvements in total life expectancy. The total number of people with disabilities will be higher in the future arising from heart disease, stroke, sensory problems, arthritis, incontinence, dementia and depression. Trends in these diseases can be used to estimate future numbers of people with social care needs.

In 2002, around 900 000 older people had high levels of need of being unable to carry out one or more of the main activities of daily living (being able to wash, dress, feed, toilet, walk and so on). A further 1.4 million older people had low levels of need. These numbers are set to increase dramatically over the next 20 years.

There is evidence of significant unmet need as the proportion of all people in their own homes who have care needs and who have those needs met is low and has been falling. Services are only being used by a relatively small proportion of people with apparently similar levels of need. Unmet need is also high among moderately dependent people. Overall the proportion of older people receiving home care in England is low by international standards.

Local authorities with good assessments for adult social care services tended to spend more than those with poorer records and there is significant regional variation.

There is a growing body of evidence relating to gains from better joint working between the health and social care systems. Partnership working is far from widespread. There has been progress in reducing delayed transfers from hospital, but this has not been matched by reductions in avoidable admissions to hospitals. Simply re-directing resources without making arrangements to coordinate and integrate those services will be the least effective strategy. The best way to measure social care performance is to examine the outcomes achieved, but this is difficult to do.

Estimating total expenditure on social care for older people is complicated by the many funding sources. In 2004/5 local authorities spend £8 billion on personal social care services; NHS spent £3 billion on long term care of older people; Attendance Allowance and Disability Living Allowance which can be used for social care paid out £3.7 billion.

There is widespread dissatisfaction with the current means tested funding arrangements for being too complex, for penalising those with savings, for the “postcode lottery” of domiciliary care charges, for perverse incentives that affect services that people receive.

Social care services are labour intensive. An estimated 559 000 people in 2003/4 were formally employed in England for core social care for older people, excluding around 120 000 NHS staff. Labour costs account for between 50-66% of the “fair price” for homes, and although pay rates have risen, vacancy rates remain high.

Informal carers provide a substantial amount of care. In 2000 in England there were about 5.8 million carers, of which older people themselves providing care were a disproportionate amount: 1 in 6 over the age of 65 were providing some form of care.

New services and technology improve the quality of older people but it can be harder to judge overall impact on costs. Telecare has shown positive results.

Demands of an ageing society are low on a list of strategic priorities for housing with demands for key workers and first time buyers taking precedence. Extra care housing provides self contained homes with round the clock support and care and has potential for independent living for some who can no longer manage in their own homes.

New models of dementia care will be important as will an increasing range of preventative measures to reduce dependency, disability and ill health. These should be targeted at those whose condition is likely to deteriorate or who have a high predicted risk of costly future needs.

## Part 2: Resource Requirements

Chapter 10 considers the aims of social care and assesses that these fall into two broad groups: first, ensuring that people are able to live in safety and satisfy personal care needs, including feeding, washing dressing and going to the toilet; second, enhancing wellbeing and social inclusion to engage socially and maintain self esteem.

Generally speaking, higher expenditure achieves a greater improvement in outcomes but spending more on social care means less money for other public services.

The Review outlines a number of scenarios for the future, reflecting different levels of ambition and achievement of outcomes:

Scenario 1 is the current service model and is the baseline case. This has been costed at £10.1 billion in 2002 rising to £24 billion in 2026 at 1.5% GDP.

Scenario 2 is the core business model that changes what the care system does, what it provides, and achieves the highest level of personal care and safety outcomes justifiable given their cost. This has been costed at £12.2 billion in 2002 rising to £29.5 billion in 2026 at 2.0% GDP.

Scenario 3 is the wellbeing model that builds on scenario 2 by providing improved social inclusion outcomes and a broader sense of well-being. This has been costed at £13 billion in 2002 rising to £31.3 billion at 2% GDP. This is similar in its policy aspiration to the Green Paper on Adult Social Care in England published by the Department of Health in advance of the White Paper.

Costing these scenarios has involved the use of four key building blocks:

- a) Assess the impact of services on outcomes. The Review uses a generic outcome measure- the ADLAY which is the gain for one year of life of having core activities of daily living needs improved from being entirely unmet to being fully met. The model set a

maximum cost of £20 000 per year for achieving each unit of outcome gain (mirroring methods used by NICE in assessing health care interventions) as a value-for-money threshold.

- b) Calculate the level of informal care and its contribution to meeting overall demand for care. This includes the outcomes of carers such as adverse effects on health and stress levels.
- c) Cognitive impairment which cause activity of daily living problems and which also generate other risks, such as to the person's safety. This can improve outcomes but increases short term costs.
- d) The impact of charges on the demand for social care services and the extent to which charges discourage older people from seeking care or reducing the amount they use. If people are put off using the services, total costs will be lower but so are total outcomes.

Additional funding is needed to improve outcomes in social care but should not be forthcoming without a commitment to reconfigure services, demonstrating value-for-money and fairness.

This includes an increase in the size of community based care packages for all those needing car, an improvement in the carer support services and tailoring of care-with-housing services for those with significant cognitive impairment.

There are several key drivers of higher cost which include improved outcomes, demographic pressure and ensuring robust and quality of supply. So even if funding were made available in the near future, supply side response would take a number of years to achieve. Spending should therefore build up on a transitional basis.

The Review team has estimated the total resources required for each of the three scenarios and on the total costs (both state and private) that would be needed to achieve better outcomes. Part 3 considers changing the funding options and moving away from the means-testing system.

## Part 3: Funding Options

This part concentrates on how to pay for social care and how to meet the funding requirements set out in part 2. The way social care is funded has changed little since its introduction over 50 years ago. Local authorities provide state funded services to those with assets below a threshold. Means testing will include the value of a house if the older person is moving into a care home but not included if the individual is receiving home care.

Other options for funding social care exist in other countries and can include social insurance models, cost sharing, limited liability models, savings based models. The approach adopted in Scotland for health and personal care is universal entitlement which is state supported and not subject to means testing.

Different approaches exist to change the current system in England which could mean raising the assets threshold above which state funded care is not provided or increasing the income level before charges are levied.

Various commercial financial products including long term care insurance products, housing equity release schemes and tax incentives may be used to assist people pay privately for the cost of long term social care.

The tests used in the Review are set out in Chapter 11 under the following headings: fairness, economic efficiency, user choice, physical resource development, clarity and sustainability/acceptability. These tests have been used to filter a broad range of funding and charging options and three options have been proposed as frontrunners:

The **partnership model** which provides 66% care funded by the state. Individuals then top up by making contributions which are matched by the state until the benchmark package is achieved. Any additional contribution made by the individual is not matched by the state. Those on low incomes make their additional contribution through the benefits system.

The **free personal care model** which provides a full package of personal care funded by the state.

The **limited liability model** which is a hybrid, and which is a means tested system for the first 3-4 years of care and then free personal care thereafter.

The **means testing model** which reflects the current funding system used in England.

A move away from the current means testing system would change the amount of care consumed, and therefore the outcomes achieved and the total (public and private) costs. This would enable the individual to decide not to buy care or to buy less care if they wanted.

The Review considers these four funding options as applied to scenario 2 and finds the following:

- **Partnership Model** achieves a significant increase in both total levels of spending and the contribution by the state to care costs. Uptake would be about 1.5 million people (an increase of about 45% over the current number). The cost would a total of £13.7 billion.

- **Free personal care model** has the highest levels of spend at £14.9 billion and the greatest funding **contribution by the state**.
- **Limited Liability Model** would increase public spending to £7.4 billion but does not bring about the changes in the number of people that use services and therefore does not change total expenditure or personal care outcomes.
- **Means Testing Model** produces the lowest level of expenditure at £12.4 billion with 1.2 older people receiving personal care.

Because both the Partnership Model and the Free Personal Care Model move to universal entitlement, over 300 000 more older people receive support compared with means testing model.

There are currently two key benefits which are not means tested: Attendance Allowance and Disability Living Allowance. These cost around £3.7 billion.

The Review proposed that both these allowances should be used to support the additional costs of funding the Partnership Model and the Free Personal Care Model. If two thirds of the amount currently spent on these benefits were transferred, it would mean the state would need to increase public social care expenditure by £1.7 billion over current levels for the Partnership Model and by £3.6 billion over current levels for the Free Personal Care Model.

The Partnership Model does levy charges, but does not include means-testing in the care system. It combines a needs-based care system with support for low-income people through the benefits system.

Both the Partnership Model and the Free Personal Care model avoid penalising people who have made financial provision for their old age, and would not require them to sell their homes.

The Review commends the Partnership Model but points out that all the models have their strengths and weaknesses. The Review considers the relative strengths and weaknesses against the tests set out above.

## Recommendations

### Funding and funding arrangements

More money needs to be spent on social care if society wants the same improvements in outcomes from social care as it wants from health. Over



20 years this target level of resource would increase up to 1.4%GDP in 2007 and 2.0%GDP in 2026.

Funding alone will not be sufficient. There needs to be a commitment to reconfigure services.

Demand for services will grow in the next 20 years and planning now is required for the financial consequences.

The Review recommends a *partnership model* for funding arrangements even while recognising that the distributional consequences fit well with some values and poorly with others.

There is a need to review disability related social security benefits, particularly Attendance Allowance which is not means tested. In addition, universal non means tested benefits such as winter fuel payments and other age related payments should be reviewed to consider whether a proportion of these funds would be better directed at improving the provision of long term care for older people.

The “postcode lottery” which allows local authorities to decide means-testing systems for domiciliary care is inequitable and greater uniformity in charging structures should be established.

Government should work with the insurance industry to model a scheme for private long term care insurance

## Services and service re-configuration

It is difficult to model the long term cost impact of technology, but telecare and workforce implications of using telecare should be part of mainstream planning in long term care for the elderly.

More emphasis on expanding dementia specific care services and training formal and informal carers is needed. This includes dementia-specific data of the cost of care at home and the services people with dementia receive.

Service reconfiguration requires an increase in the number of community based home care packages for people with high levels of dependency and for people with moderate levels of dependency.

Service reconfiguration requires a need to distinguish between housing and care costs, and to assess care and housing services.

Service reconfiguration needs significant funding to help carers with their support services and relevant technology. A focus on spousal carers support needs should be a greater focus than the services for the cared-for people. For filial carers, a range of options needs to be considered.

Service reconfiguration needs services targeted at improving well-being including initiatives to tackle loneliness and social isolation.

An increase in resources aimed at “middle” if not low-level social care is recommended with immediate benefits on service user outcomes the expected result. It is anticipated that these services would have long term prevention effects reducing future need.

## Processes

Policy on health and social care integration should continue to develop, subject to better confirmation of expected cost effectiveness of the component parts.

National criteria are urgently needed to draw a clear line between long term health/nursing care and social care. Where the former are the primary need, then the NHS should cover the costs of long term care in a way that is consistent with other NHS care. An increase in the intensity of personal social care provision (heavily supported by the state) is recognised in this Review and will limit the “cliff edge” between the health and social care systems as will adoption of the partnership model. There is an important distinction to be made between housing or hotel and care costs, and especially the basis on which these different types of costs are met.

Both health and social care organisations should be given greater incentives to pool resources and clarify joint funding streams. The current mechanisms are facilitating and passive, and more active financial encouragement is required such as financial incentives to pool resources.

More flexibility and choice in the range of support services available to carers is required both for services and access to those services. There should be an increase in assessment of carer needs and support required to enable cost effective use of services.

Costs saving in new models of care, such as telecare and extra care housing needs to be recognised when apportioning budgets to encourage implementation.

## Information and evidence

Social care evidence base is under-developed and research funding should be increased with comparative research and systematic review. There should also be a full examination of English Longitudinal Study of Ageing, and a dedicated survey of disability. Further research is needed in unmet need.

A comprehensive assessment of the total amount being spent on private expenditure by older people on social care is urgently required, particularly self-funding of domiciliary care and third party “top-up” care home fees.

Methods of data collection should be established for the workforce to achieve an assessment of supply responsiveness, impacts of technology and service development:

- independent sector workforce size and structure (Skills for Care has developed a minimum data set which initiative is applauded)
- agency staff numbers and patterns of employment
- immigration and migration workforce numbers and trends
- overtime rates and de facto increase in staffing levels

The link between workforce training and quality of outcomes needs to be clearly established. This should assess the real costs of training and current capacity for training, maximum training within existing structures and additional infrastructure necessary to increase training levels.

Evidence needs to be developed about service outcomes, in particular cost effectiveness of extra care housing, care home placements (for people with cognitive impairment), day care services and carer support services. This should also include the cost effectiveness of prevention and preventative services.

Evidence is needed to develop and scale measures of carer outcomes.

Research is needed on how Attendance Allowance and Direct Payments are spent by recipients.

## Methods

There should be the adoption of an outcomes approach and resource decisions should be assessed for implications of outcomes for service recipients.

The Review recommends in particular the use of generic social care measures, particularly the OPUS project and the work to value preferences as an integral part of resource allocation and policy development.

There should be greater alignment of resources around a value-for-money principle (including how it should be defined in social care) balanced with other principles such as fairness and sustainability, along with the

appropriateness of cost-outcome thresholds and the valuation of those thresholds in social care.

Standard ways to measure the outcome of preventative services need to be developed to allow comparative studies and a more robust evidence base to be collected.

## Next steps for the RCN

The RCN will be conducting further analysis of the content of the Wanless Review and placing this in the context of the wider Health and Social Care Reforms project of the Policy Unit. Dissemination of the content of the Review and the reaction of members to the proposals are likely to produce some fundamental questions about the nature and basis of funding of the welfare state. These discussions and the issues raised will be used to inform RCN position statements and influence wider RCN policy across nursing.