TONY BLAIR INSTITUTE FOR GLOBAL CHANGE

Fair Social Care: Priorities and Funding Options

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Published at https://institute.global/policy/fair-social-care-priorities-and-funding-options on September 7 2021

Executive Summary

- The social-care system in England is in a bad state. The Covid-19 pandemic has brought some of its problems into stark perspective and increased attention on the need for reform. At the start of the pandemic, inadequate resources available to care workers prevented them from stopping the spread of the disease. The government has recently suggested a 1 per cent National Insurance contributions (NICs) rise to provide additional funding for social care. In this paper, we focus on the immediate priorities for reform, and examine this and other funding options.
- In recent years, growing demand from both a growing elderly population and working-age disabled adults has collided with drastic cuts to local authority budgets. The result has been rapid growth in unmet need for social care, increased pressure on unpaid family carers and widespread failure of care providers no longer able to make the finances work. At the same time, pay for carers has been held down, resulting in a demoralised workforce, and high turnover and vacancy rates.
- We argue that the immediate priority has to be to stabilise the existing system by providing more funds to support those not receiving the care they need and to help out family carers. It could cost up to £10 billion to restore peak per-capita funding levels. Staff pay will also need to be increased to ensure it does not fall too far behind similar positions in the NHS. There is also a strong case for the state to provide insurance against catastrophic costs as private markets have failed to develop.
- Providing insurance could follow the Dilnot Commission's proposal for a monetary cap on care costs and a more generous asset test. However, concerns have been raised that this would still leave those with modest levels of assets using a significant fraction of them to pay for care. In the context of concerns about levelling up, this approach has its drawbacks, still leaving homeowners in less wealthy parts of the UK at risk of losing a larger share of their assets than those in the better-off South East.
- We propose a more progressive alternative cap set at a fixed percentage of an individual's initial assets. With this approach, the state would step in once a care user had contributed 15 per cent of their assets towards the cost of care.
- In the longer term, advances in medical science may weaken the link between an ageing society and additional pressure on the social-care system. Any solution for the short term must not assume that things will look the same in twenty years' time. Given that younger people may face a lower risk of requiring social care in later life, asking them to pay more in tax now to improve social care would be unfair.
- This is the major problem with the government's proposed 1 per cent rise in all NICs rates: it would leave the cost of improvements in social care falling almost entirely on those of working age and tax labour income rather than those who have benefited from the boom in asset prices of recent years. It would also exacerbate existing differences between the tax treatment of the employed and the self-employed.
- We examine other funding packages that would be more progressive and place more of the burden

on older generations. These include an increase in income tax for the over-40s, replacing council tax with a tax that is proportional to property values and reforms to capital gains tax.

- Given the political difficulties that have arisen finding a funding solution, a cross-party commission to agree an acceptable funding measure may be the best way forward. By coming together to address an issue on which there is already broad consensus, as happened on pensions policy in the mid-2000s, policymakers have a chance to make a real difference to the lives of many vulnerable people.

Introduction

Two years after the Prime Minister pledged to fix social care on the steps of Downing Street, the government finally looks set to act. Having promised on entering office that "[m]y job is to protect you or your parents or grandparents from the fear of having to sell your home to pay for the costs of care… And so I am announcing now … that we will fix the crisis in social care once and for all, and with a clear plan we have prepared to give every older person the dignity and security they deserve," Boris Johnson's plan looks set to finally be revealed. It seems likely to be funded by a 1 percentage point increase in all National Insurance contributions (NIC) rates. But as has happened so often over the last 25 years, opposition from Labour and disquiet from within the Conservative party, even from cabinet ministers, [1] has been quick to raise its head.

Reform is certainly well overdue. Poorly understood by those who have not had experience of using it, underfunded and subject to an unpopular means test, the system is in a bad state. Yet little reform has taken place in the past 30 years. All attempts to find a solution have run into political difficulties.

Could this time be different? Covid has brought some of the problems in the social-care system into stark perspective. The ONS has estimated that there were more than 25,000 excess deaths in care homes in 2020. As well as hospitals discharging patients to care homes without testing them for Covid first, it is likely that the inadequate resources available prevented care workers from stopping the spread of the disease. For example, the ONS has shown that care homes that used agency or bank staff had a greater number of infections among residents than those that did not. And the issue has risen up the agenda in recent years, becoming a key factor behind Theresa May's government losing its majority in the 2017 general election.

Over the past 25 years, proposed reforms have focused on increasing the generosity of provision to those who do not receive any support under the current means test. But other problems have also arisen over the past decade, with cuts to local-authority spending imposing stricter rationing on access to care, and leading to problems recruiting and retaining staff. Rather than dusting off old proposals, then, this is surely time to think strategically about the immediate priorities for reforming a system that is under serious strain.

Solving the problems in the social-care system will be expensive. As we head towards the spending review, and a meaningful chance that the government will act to tackle the problems in social care, it is critical that we take the opportunity to get this right. If we make the wrong decisions, subsequent reform may prove even more difficult. This paper sets out the context to these critical decisions, highlights the priorities for reform and outlines a range of different funding options that could measure up to the scale of the challenge.

Trends in Social Care

The social-care system as we know it has existed since the early 1990s when responsibility for social care was transferred to local authorities. It was introduced in response to two problems with the previous system. Under that system, the social-security budget would pay for the cost of care homes but not domiciliary care, so there was a strong incentive to put poorer elderly people in residential care even if they would have been better off being cared for in the community. Second, leaving poorer elderly people in one of 50,000 "long-stay" beds in the NHS to see out their days was no longer considered acceptable by the late 1980s. The solution alighted upon was to transfer the funding to local authorities to deliver the care they consider most appropriate to meet individuals' needs.

Local authorities assess both an individual's need for care and their ability to pay for it according to prescriptive rules laid down by central government. Unlike in most other OECD countries, support is highly means-tested, with care users having to exhaust nearly all their assets before the state will step in. [2] In other countries, entitlement to long-term care services is paid for by the state with only small out-of-pocket payments by users. In the Nordic countries, this is financed through general taxation. As in England, care itself is organised by local authorities, but the Nordics are different in that local authorities raise income taxes to pay for care themselves. Other OECD countries finance social care through the social-security system; in some, including Germany, Japan and the Netherlands, there are specific social-security contributions that go towards social care, whereas in others, such as Belgium, it is part of the health-insurance system. Other countries have mixed systems, like that in Scotland, where some aspects of social care – most often nursing care in care homes, but sometimes personal care too – is provided by the state but support for other components such as living costs in care homes is means-tested, though typically the means test is not as harsh as in England. [3] Only the US has a means test that is comparable to that in England.

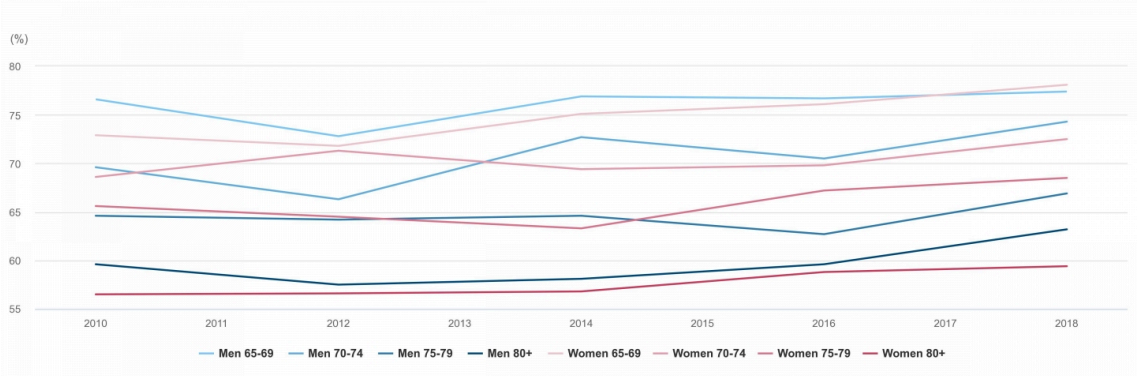
During the 2010s, local authorities' budgets were squeezed. This forced them to cut back on the support they offered: care needs now have to be "substantial" to receive any help at all. Spending on adult social care was roughly the same in real terms in 2019–2020 as it was in 2009–2010. [4] There were fewer over-65s receiving residential social care in 2019 than a decade earlier, and a third fewer receiving domiciliary or community-based care. The number of people receiving publicly funded care fell by 400,000 between 2009–2010 and 2013–2014 and has since continued to fall slightly. [5] Although those most in need of care still receive it, many of those with less severe care needs no longer receive support, leading to a greater burden on family carers.

At the same time, demand for social care has been growing both from elderly people and those of working age. The size of the over-65 population increased by 23 per cent between 2009 and 2019.

Demand for long-term care from working-age adults has risen too as improvements in health care have led to longer life expectancies of some of those with physical and learning disabilities. [6]

Nevertheless, there is some evidence that improved health at older ages has helped constrain growth in demand. Demand for social care, on a per-person basis, may be falling as life expectancy increases. The number of requests for support from elderly people to local authorities has not increased as quickly as the size of the over-65 population. [7] This may have arisen because of well-known funding shortages (see next section), but there is also evidence that as life expectancy has increased, so has the health of the older population. Older people are more likely to report that their health is good than they did ten years ago (Figure 1). Similarly, the Health Survey for England shows that the proportion of over-65s requiring assistance with an activity of daily living fell from 32 per cent in 2011 to 27 per cent in 2018. [8]

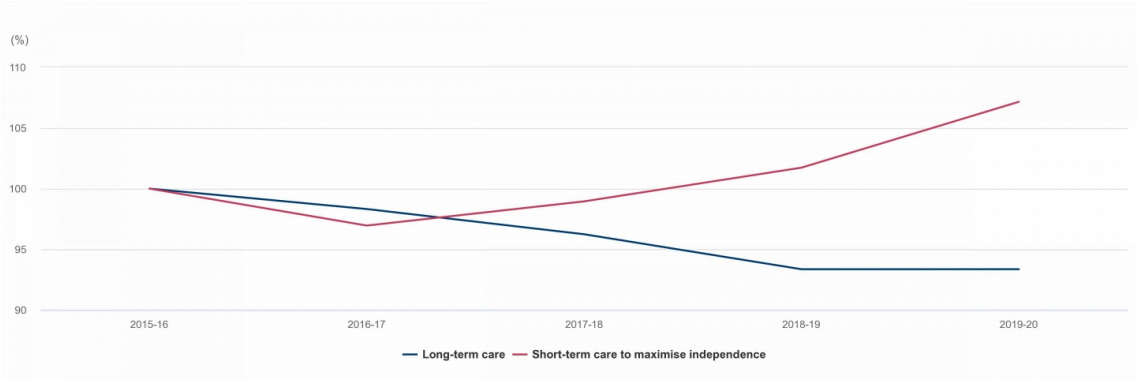
Figure 1 – More elderly people are reporting their health status as good or better



Source: TBI calculations using ELSA waves 5-9 reports.

There have also been changes in the type of care that people receiving care from local authorities are using. Fewer older people are receiving long-term care packages, with increased use of short-term packages designed to maximise independence. The intention is to reduce the requirement for long-term support. This approach is on the face of it relatively successful – the most common outcome (36 per cent in 2019–2020) is that service users do not have any ongoing need for support, and less than 20 per cent require long-term care – though this may also be evidence of rationing of care services. [9] It has not been possible to formally assess the effectiveness of these so-called "asset-based" or "strength-based" approaches to care that aim to signpost individuals to less formal forms of support or build up their independence, resilience and ability to make their own choices. [10]

Figure 2 – Percentage of older people (age 65+) in long- or short-term care, from 2015-16 baseline



Source: Adult Social Care

Another recent innovation in the Social Care Act of 2014 has been the introduction of personal-care budgets. Users can opt to receive a direct payment from their local authority and arrange care themselves rather than simply receive services. The option of direct payments initially proved popular, but numbers using direct payments have fallen since 2017–2018. [11] Users have reported that direct payments are not working as originally intended as they have not been given the help they needed to organise their care package, or felt that the options available to them were restrictive. [12] In practice, direct payments are most useful for those who wish to employ a personal carer or assistant.

As the population ages, pressures on social care are likely to grow, particularly if, as is currently the case, increases to life expectancy continue to outpace increases to "healthy life expectancy". [13] However, technological developments and continued improvements in health at older ages can offer the potential to relieve these cost pressures.

On the technology front, the pandemic has necessitated a significant increase in the use of telemedicine – the use of digital means to provide patient consultations, monitoring and care – across all aspects of health care. The implications and opportunities of this for cost-efficient social care is enormous. Meanwhile, virtual assistants can give reminders to take medication, reducing the need for care visits to check on their welfare.

Novel wearable technologies can already be used to remotely monitor vitals, such as heart rate, temperature and blood-oxygen levels, and as the utility of these devices continues to expand, they will play an increasingly important role in more personalised and effective outpatient care. Other sensors installed in the home can also support remote monitoring of care users, for example, to track and optimise room temperature or recognise abnormal electricity usage, which could indicate an individual is in need of attention. Local authorities are already introducing these technologies. [14] New possibilities emerging from the Internet of Things mean some of these devices will be able to exchange information to optimise their outputs or draw more insightful conclusions.

Other opportunities include soft robotics, exoskeletons and smart walkers that could help with mobility, potentially allowing those with mobility issues to remain in their own homes rather than requiring residential care. Robots might also offer companionship and interaction with older people, which might slow down the onset of dementia. [15]

In the longer term, medical advances will be vital in creating treatments for conditions that currently cause people to require social care. Advancements in biomedical research and biotechnology, are enabling unprecedented insights into the mechanisms of disease and how they can be predicted, prevented and treated. Emerging technologies, such as personalised genomics (and multi-omics), gene therapies and immune therapies will be critical in delivering precision medicine, keeping people healthier for longer and reducing their need for social care. Therefore, although there is a need for urgent action to deal with today's problems, the situation may be very different in 20 years' time. Reforms should not lock us in to a system that may not be suitable in the future.

The remainder of this report focuses on the immediate issues facing the social-care system and possible funding options.

Problems With the Current System

In the next part of this report we set out the various problems that exist with the current social-care system and how these could continue to worsen if no action was taken before discussing possible solutions and potential solutions.

Large Out-of-Pocket Costs

The harsh means test for support with social-care costs can lead to large out-of-pocket costs that wipe out a large fraction of care users' assets, leaving them with little to bequeath to their heirs. Those with assets of more than £23,250 must pay the full cost of their care. For those in residential care, this includes the value of their main home (so long as they do not have a partner still living there), but main residences are disregarded from the means test for those receiving domiciliary care. Those whose assets are less than this amount must contribute an amount related to the amount above £14,250 and all of their income above a small disregard. Again, the disregard is smaller for those in residential care (a personal expenses allowance of £29.30 a week) than for those receiving domiciliary care (the pension credit guarantee, which is £177.10 for a single person or £270.30 for a couple).

This is the most widely discussed problem with social care. The contrast with health care, which is free at the point of use for everyone, is striking. The difference in the treatment of those who receive domiciliary care, who would always be able to leave their primary residence to their heirs, and those who have to move into a care home, who could have to sell their home and potentially use almost all of the proceeds to pay for care could be seen as unfair too. For this reason, most proposed reforms have concentrated on making the means test more generous and limiting the amount people have to pay for care.

At one extreme, this would involve the creation of a "National Care Service" that paid for all care needs, including the cost of accommodation and living expenses in care homes. This would be expensive: currently self-funders pay £11 billion in care costs each year, though not all of this would be eligible for local authority funding. Simply applying average local authority spending to self-funders reduces the cost to around £6 billion. [16] However, in the current climate, simply doing this would cause other problems. With reductions in local authority funding, self-funders in care homes pay a much higher fee than those whose fees are paid by local authorities – the Competition and Market Authority found in a 2017 study of larger providers that self-funders paid 41 per cent more. [17] Increasing the number of people who receive local authority support would therefore also require an increase in the rates paid by local authorities, otherwise many care home providers who are already struggling would go under. This would

increase the cost of implementing these reforms. Furthermore, it is likely that there would be greater demand for care from those who would have to fund their own care under the current system but currently have unmet need, raising the cost even further.

More modest reform proposals have included free universal personal care, as in Scotland. Under this model, domiciliary care is completely paid for and care home residents receive a universal contribution towards the costs of their care, but still have to pay for accommodation and living costs out of their own pocket to the extent that they are able to do so. It does little to limit the out-of-pocket costs faced by those in residential care for a long time: the Free Personal Care Allowance in Scotland only covers around 25 per cent of care home fees, [18] and there is no cap on lifetime care costs. The Health Foundation has estimated that replicating this model in the rest of the UK would cost £5 billion a year. [19] The Scottish experience shows that this might lead to increased demand for formal care, particularly home care. [20, 21]

For these reasons, in England the focus has been on the Dilnot Commission's proposals to cap lifetime care costs and make the asset test more generous so that individuals do not have to use almost all their assets to pay for the costs of care. Introducing these with a cap of £78,000 as the coalition government proposed in 2013 would cost £2 billion a year. A lower cap of £46,000, closer to Dilnot's central recommendation in today's prices, would cost £3 billion. [22]

There is a strong case for greater financial support for those facing high care costs. Private-insurance markets have failed to produce products to adequately cover people against this risk, so it is likely that people would value the provision of greater social insurance. However, there is still a case for individuals to make a contribution towards their care costs to avoid overuse of care services. This partnership model also fits with public preferences. Deliberative workshops with members of the public have found that when the current system's lack of generosity is explained, there is strong support for reforms that would provide greater support with care costs, [23] but equally that people are realistic that not all costs can be paid by the state. [24] Something along the lines of these Dilnot proposals would therefore be likely to garner significant support, at least among those who had a good understanding of the issues.

The power of the Dilnot proposals is that the cap on care costs removes the risk that people will face extremely large care requirements that wipe out most of their wealth. At the same time, a more generous assets test that expands support to those with assets of up to £125,000 ensures that the state comes to the aid of people in the bottom quarter of the wealth distribution before they reach the cap.

However, concern has been raised that, even with this additional support for those with modest assets, the proposals mean that people in the bottom half of the wealth distribution would still be on the hook for a much larger proportion of their more modest wealth than their wealthier counterparts. For example, if the cap were £46,000, those with total assets of around £120,000 could lose up to a third

of their assets in care costs (Figure 3). This would have starkly different effects in different parts of the country. For example, paying care costs of £46,000 would represent 32 per cent of the average house price in the North East but just 9 per cent of the average London house value. In the context of wider policy concerns about levelling up, this design feature seems to take us in the wrong direction.

But it is possible to solve this problem and make the system more progressive, while retaining the core benefits of the Dilnot proposals? Rather than setting a cost cap *and* extending means testing, [25] it would be fairer and simpler to set a cap as a percentage of an individual's initial asset levels. This would be better targeted towards the objective of preventing long-term care users facing catastrophic costs that wiped out a large proportion of their asset base. It is likely that a maximum contribution towards care costs of around 15 per cent of assets would cost around the same as a £46,000 cap on care costs and extending means-tested support to those with assets of up to £125,000.

This proposal would lead to those with assets of less than around £200,000 hitting the cap after one year in an average care home as opposed to nearly two years under the Dilnot proposals. The contribution towards fees for those with modest levels of assets of between £120,000 and £170,000 who did have long spells in residential care would be more than £20,000 lower under this alternative proposal. By contrast, the wealthy would have to stay in residential care for more than three years to benefit from a cap set at 15 per cent of initial assets and would potentially have to pay significantly more towards their care than they would under the Dilnot proposals. However, they would still benefit from protection against the risk of extremely high care costs to which they are exposed today. An individual with assets of £500,000 on entering care (the median level of assets among the over-65s in the 2016–2018 period according to the Wealth and Assets Survey) [26] would pay half what they would have to under the current system if they faced lifetime care costs of £150,000.

One objection to a cap set as a percentage of initial assets might be that a cap set as a proportion of initial asset levels would not provide meaningful insurance to wealthier groups. The care bill for a person with assets of £2 million is very unlikely to reach a 15 per cent cap of £300,000, hence they would effectively face the full costs of their care. But it is far from clear that the state providing insurance for such people is a policy or political priority. If it were still considered desirable to offer this insurance, one option would be to introduce a system of voluntary, cost-neutral, state-provided insurance, along the lines recently proposed by Lord Lilley, alongside this cap on care costs. [27]

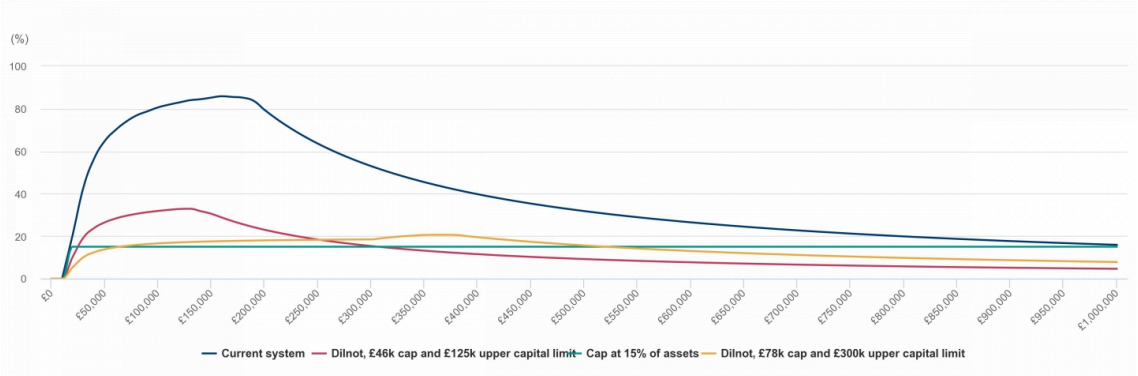
Other potential problems of a proportional cap are administrative. Unlike the Dilnot proposals, where almost all homeowners would simply pay their residential care costs up to the cap, everyone entering the social-care system would have to undergo an assessment of their asset levels to calculate their maximum contribution towards care costs. There would be a stronger incentive for fraud: individuals would pay less if they gave away or failed to disclose assets. But since those with high levels of assets would only hit the cap if their care costs were very high, this incentive would be rather weak for those most able to engage

in complicated financial engineering. In almost all cases, the rich would simply pay all their care costs as they do at the moment.

Questions also arise as to whether primary residences would be included in the definition of assets for both domiciliary and residential care users. If it were included for both domiciliary and residential care users, it would increase the contribution paid by those using domiciliary care. [28] This might allow the cap to be set at a lower level. An alternative would be to continue the current system whereby only residential care users see their home included in the assets assessed for the means test. Someone who had contributed 15 per cent of their other assets towards the cost of their domiciliary care would then potentially have to put up to 15 per cent of the value of their home towards their residential care. This would, however, require two asset assessments to be made: one on starting domiciliary care and a second on entering residential care.

If these problems could not be overcome, a similar outcome could be achieved by tweaking the Dilnot proposals so that the cap was higher and the means test extended even further. For example, the cap could be increased to £78,000 – approximately the level proposed by the coalition government in 2013 – the upper capital limit to £300,000 (rather than £125,000) and additional support given to those with assets below this level. Rather than having to contribute £1 a week for every £250 of assets above £14,250, this could be reduced to £1 for every £750. Under this system, all those with assets between £30,000 and £780,000 would face a maximum contribution of between 10 per cent and 21 per cent of their assets (Figure 3). This system thus approximates a proportional cap quite well. It also ensures that only those with assets of less than £378,000 would ever have to undergo an assessment of their assets, easing the administrative burden considerably. And as with the original Dilnot proposals, it would provide insurance against the very highest care costs even to the wealthiest.

Figure 3 – Maximum asset depletion for an individual in residential care with total care costs of £150,000



Source: TBI calculations.

Note: Assumes residential care costs of £36,500 per year of which £10,000 represent general living costs that are covered by the individual's income.

Cost Pressures Lead to Unmet Need and Provider Failure

High out-of-pocket costs are not the only, or even the biggest, problem with the system, however. Cutbacks in local authority budgets have led to a substantial unmet need for care. Among the elderly population, Age UK estimate that 1.5 million people aged 65 and over have unmet care needs. [29] Around a million of those who have problems with a basic activity of daily living receive no help at all [30] and those who do still receive care receive less. Despite NICE guidelines recommending against care visits of less than half a hour in most circumstances, health and welfare charity Leonard Cheshire Disability have estimated that more than 20,000 people still receive care visits of only 15 minutes, leaving users having to choose between getting dressed and having a cup of tea. [31] That said, official estimates of the quality of care provided and surveys of user satisfaction show little of concern: five out of every six providers are rated "Good" or "Outstanding" by the Care Quality Commission, [32] and around two-thirds of care users are very or extremely satisfied with their care. [33] On the other hand, carers are less satisfied with the care provided: less than half are satisfied with what the person they care for receives, [34] and there is some evidence that although the number of complaints received by the Local Government Ombudsman has remained static, the seriousness of them has increased. Overall, then, there is significant evidence that cuts to local authority budgets have impacted on the quality of care received.

The Health Foundation has estimated that to bring coverage levels back to 2010–2011 levels on a per-capita basis would cost £10 billion a year in 2023–2024. [35] This assumes that demand growth would have risen in line with projections from the Personal Social Services Research Unit (PSSRU), which in turn assume that rates of disability by age remain constant. [36] In reality, there is some evidence that rates of disability have fallen among older people, and increases in productivity in the care sector may have reduced the cost of providing this care so this cost may be slightly lower.

This funding squeeze has destabilised care providers. Care itself is on the whole not provided by local authorities themselves. Rather, services are contracted out to a wide range of private and voluntary sector providers. As local authority budgets have been cut, providers have faced increasing pressure too, being unable to increase the prices charged to local authorities even as their costs have increased with rises in the National Living Wage. The result has been providers handing back contracts to local authorities as they are no longer profitable, and closures. In 2019, 75 per cent of local authorities surveyed by ADASS reported that at least one care provider had closed or handed back a contract in the previous year, [37] and the number of care and nursing home beds have both fallen relative to the size of the elderly population. The number of care home beds per 100,000 people aged 75 or over fell from 11.8 in 2012 to 10.8 in 2020, and the number of nursing home beds per 100,000 from 5.7 to 4.7. [38] Indeed, a number of large care-home groups including Care UK, Saga and Housing & Care 21 have withdrawn from the publicly funded care-home market. Southern Cross went out of business in 2011 and

the company that took over the running of its care homes, HC-One, is reportedly for sale, and Four Seasons Healthcare went into administration in 2019. Another large provider, Mitie, was sold in 2017 for a nominal sum having run up large losses. [39]

There is therefore strong evidence that the amount paid by local authorities for social care is insufficient to provide a quality service. To survive, providers must cut costs aggressively. Both the lower quality of care and the instability resulting from potential provider exit this creates are bad for care users. Additional funds to stabilise the existing system are therefore an urgent priority. Moreover, this is only likely to worsen in the near future. Pressures from growing demand from the working-age population are likely to continue, as are those from older people as the population ages. This would not be cheap: the Health Foundation has estimated that merely maintaining existing service levels while meeting the additional demand from an ageing population would cost £2.1 billion a year by 2023–2024, and returning to 2009–2010 service levels £7.9 billion more. [40] This would allow local authorities to deal with the most urgent problems with the current system and restore some of the services that have been pared back over the last decade. In particular, this would give additional resources for working-age disabled adults, who are reliant on the state to pay for their care, to give additional support to unpaid family carers and to increase access to domiciliary care. Early intervention may lead to reduced need for older people to move into a care home later on.

Staff Shortages

This budgetary pressure has also been passed on to staff. Although care workers have benefited from increases in the National Living Wage, hourly wages have fallen behind those of other low-paid professions. Whereas shop workers and cleaners were paid less than care workers on average in 2012, this had reversed by 2019. [41] Comparisons with jobs that might be available elsewhere are more stark: the starting salary for a nurse in the NHS is around 7 per cent higher than that of someone doing a similar job in a care home, rising to 22 per cent for more senior nurses, and care workers could earn around 20 per cent more doing a similar job in a hospital. [42] The result has been growing numbers of vacancies in the sector – 7.2 per cent of posts in the care sector were vacant in 2019–2020 compared to 4.4 per cent in 2012–2013 – and increasing rates of staff turnover, with annual turnover rates rising from 21.7 per cent to 31.9 per cent over the same period. [43] Brexit adds a new dimension to the problem of recruitment: in recent years, many new recruits have come from other EU countries: 7 per cent of staff hold EU nationality [44] and the new immigration rules will exclude 80 per cent of care workers. [45] One way to address problems of recruitment and retention would be to increase pay for social-care roles to match recent increases in the pay for equivalent roles in the NHS and continue increasing pay at this rate until 2023–2024. The Health Foundation estimate that this would cost around £1.8 billion a year in 2023–2024. [46]

It is less clear that fixing this problem is an urgent one. Turnover rates increased as the economy recovered from the global financial crisis, so could be expected to fall again if unemployment is higher in the post-Covid period. On the other hand, new restrictions on immigration post-Brexit will cause one source of new care workers to dry up. Nevertheless, it will almost certainly not be sustainable in the long term for care workers to be paid less for their work than for equivalent roles in the health service.

Increased Burden on Unpaid Carers

Another potential source of care for those who require it is unpaid care from family and friends. They have picked up the slack from the reduction in availability of formal care paid for by local authorities and have received less support while doing so. The number of people claiming Carer's Allowance has risen from under a million in 2009–2010 to nearly 1.2 million in 2019–2020. Carer's Allowance is a largely forgotten benefit: its level is very low at only £67.25 per week and unlike other income replacement benefits has not been increased during the Covid pandemic. In return, recipients have to provide at least 35 hours a week of care to someone claiming a disability benefit and are unable to earn more than £128 a week from other paid work.

As a result of funding cuts since 2010, fewer carers are receiving support from their local authority and, as already mentioned, they are becoming less satisfied with the care the person they care for receives. The number receiving support such as direct payments, personal budgets, commissioned support, providing advice, other universal services or signposting to other forms of support fell from 437,000 in 2014–2015 to 376,000 in 2019–2020.

This all puts a heavy and growing burden on those who take on caring responsibilities. The proportion of carers who give more than 100 hours of care a week has increased from 36 per cent in 2012–2013 to 39 per cent in 2018–2019. [47] A survey by Carers UK found that around half of carers had not been able to take a break from their responsibilities in the last five years. [48] Greater support for unpaid carers might encourage more people to take on this important role, potentially reducing the cost of formal care as well as giving much-needed support to a group of people that provide a valuable service to the community.

What Happens If We Do Nothing?

Continuing with the existing system of funding social care will lead to the same trends that we have seen over the past decade continuing; namely, greater rationing of care as funding fails to keep pace with demand. Not increasing the social-care budget will force services to be rationed even more strictly in the future: with the population aged 85 and over – the group most likely to require social care – forecast to

nearly double between 2018 and 2043, [49] this would surely leave many of those requiring care unable to access it. Relying on family carers to step in would also be unwise: with future cohorts of older people having higher divorce rates and smaller family sizes and growing labour-market participation among older working-age women, demand for informal care is likely to outstrip supply. [50]

It is important to caveat this assessment somewhat. First, economic growth should allow spending to increase somewhat in real terms over the coming decades. It should be possible for both grants to local authorities and council tax rates to increase in line with growth in the economy, allowing local authorities to spend more on social care than they do today. Second, as discussed previously, the health of the elderly population has been showing some signs of improvement over the last decade and this trend may continue.

Nevertheless, it is safe to assume that tax revenues will fail to keep up with demand for social care. The increase in the very elderly population is not just due to rising life expectancy, but also the impact of the 1960s baby boom: members of this larger cohort will be in their 80s by the 2040s. The PSSRU estimate that public expenditure will need to increase as a share of national income by roughly two-thirds between 2015 and 2040 to maintain service quality at its (already inadequate) 2015 levels. They project that the cost of the current public social-care system will increase from 1.06 per cent of national income in 2020 to 1.42 per cent in 2035, an increase of around £8 billion a year in today's terms. [51] Although this could be offset by further improvements in health at older ages or technological advances that reduce costs, there is a risk that even returning funding levels to 2010 levels will be insufficient to keep up with demand in the longer run. Ensuring that any potential cost-saving technologies are embraced will therefore be a priority.

Muddling through by relying on council-tax increases is also not a long-term strategy. Previous attempts to raise council tax significantly between 1996 and 2003 did not prove sustainable. In response to concerns about high levels of council tax, central government reintroduced "capping" of local-authority budgets from 2004 to limit bills, and this was then followed by further efforts to restrict council-tax rises under the coalition government from 2010. Additional grants were given to local authorities to freeze council tax between 2011–2012 and 2015–2016, and those that wish to increase council tax by more than a set threshold (usually 2–3 per cent) must put this to a referendum. This has been effective in limiting council-tax rises and had the effect of essentially centralising the funding of social care. Only one referendum on council tax rises has taken place since these rules were introduced in 2012–2013 – the police and crime commissioner for Bedfordshire wanted to increase the precept by 15.3 per cent in 2015–2016 – and this was rejected by a greater than 2-to-1 margin. Nor will nationalisation, as some in the Labour party have advocated, lead to lower costs: it is not the case that private providers are draining huge profits out of the system; on the contrary, they are struggling to remain solvent.

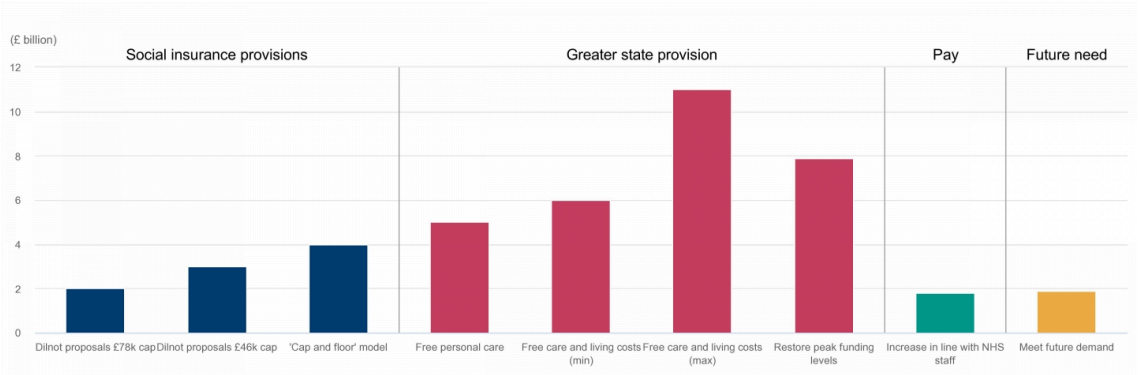
The situation is therefore somewhat different to the problem of pensions reform that faced policymakers in the 2000s. Although the numbers of people requiring social care will likely not increase as quickly as the population ages, there is no equivalent to raising the state pension age as a way in which costs can readily and fairly be reduced: restricting the number of people who are entitled to receive social care would cause great hardship. This calls for different solutions to address the rising costs of social care.

Summary

There are several problems with the existing social-care system. The existing means-tested system is severely underfunded, leaving many who need care without support and putting increasing pressure on family carers. Staff are leaving the sector, leaving vacancies unfilled. And unhappiness with the harsh means test for support remains. Solving each of them will require some level of increased funding. The cost of different policies that have been suggested is summarised in Figure 4. The combination of improving care coverage, increasing staff pay and implementing the Dilnot proposals would therefore be expensive: around £14 billion per year from 2023–2024. Funding this will be a big challenge since this is the issue on which reform efforts over the last 25 years have foundered.

The government has mooted a 1 per cent increase in all NICs rates, which would be sufficient to fund a package along these lines. In the next section, we discuss the problems with using NICs to fund social care and suggest other potential funding packages.

Figure 4 – Cost of reform proposals



Source: Health Foundation (various).

Note: Costings all in current prices for implementation in 2023–2024, except free care and living costs which is an estimate for immediate implementation.

Funding Sources

As we have seen, a package of reforms that comprehensively deals with the problems in social care would be expensive. Increasing spending on the existing system to enable it to cope with future pressures and reverse cuts that have led to greater rationing of care, introducing the Dilnot proposals to cap care costs and make the means test more generous and increase staff pay would cost around £14 billion a year. But as we have seen, previous attempts to reform the social-care system have foundered on the issue of funding.

The government has mooted a 1 percentage point increase in all NICs rates to pay for increased spending on social care. This is a straightforward increase in one of the three main taxes (together with income tax and VAT) that make up two-thirds of total tax revenues. It would increase tax revenues in 2023–2024 by around £13 billion.

This approach has some precedent internationally. Faced with similar issues in their social-care system in the 1990s – an ageing society, pressure on the finances of local and state government from social-care costs, and increasing reliance on family carers – Germany introduced a similar policy. [52] An additional social-security contribution was introduced in 1995 to cover the cost of long-term care insurance, based on the existing health-insurance contribution. This is slightly different to NICs in the UK as contributions are capped for higher earners in the German social-security system, and pensioners must also pay health and long-term care contributions out of their pension income. The German approach therefore ensured that the costs of paying for long-term care were spread out among all generations.

A NICs rise in the UK, by contrast, would leave the burden of paying for improvements in social care almost entirely on the shoulders of the working-age population, since pension income is not subject to NICs and even those who remain in paid work above state pension age do not pay NICs on their earned income. Our analysis using UKMOD (see Figure 5 below) shows that an increase in NICs rates would reduce the incomes of households headed by someone in their 20s by £200 a year on average, whereas pensioner households would be unaffected. [53]

The second problem is that, as we have pointed out in previous work, increasing NICs would add to problems in the tax system that have arisen over recent decades that have left land and property, pensions and capital gains undertaxed relative to income from work. The main beneficiaries of this have been the wealthiest. In particular, the combination of increases in NICs rates and cuts in income tax rates has led to a growing gap in the taxation of earned and unearned income. [54] Also, by increasing both employee and employer NICs rates, the well-known difference between taxation of the employed and the self-employed would be increased. [55]

In the remainder of this section we outline three alternative packages of reforms that would raise around the same as a 1 per cent increase in all NICs rates in a more intergenerationally fair and progressive way. We also examine whether there are non-tax forms of funding, such as voluntary or compulsory insurance or compulsory saving that could fund this expansion of state provision for social care.

Option 1: An Income Tax Increase for the Over-40s and Means-Testing Winter Fuel Payments

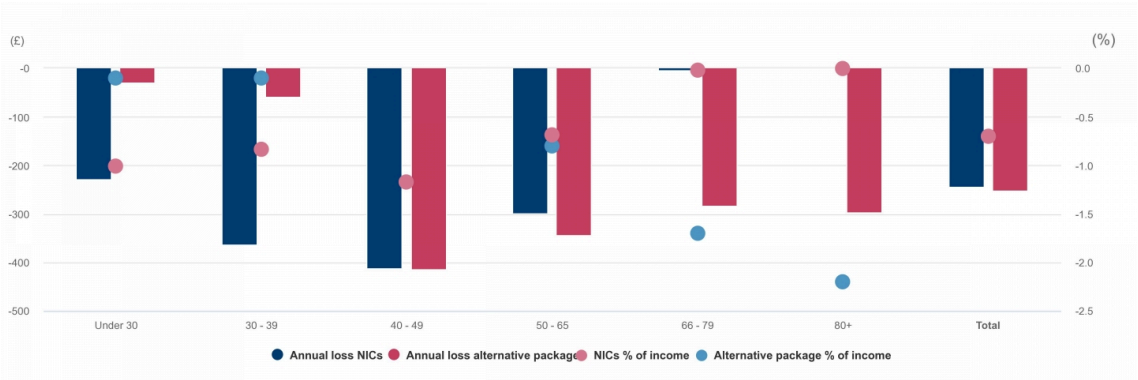
Expecting younger generations to bear the brunt of paying for improvements to social care seems unfair. By the time younger people come to benefit from social care, the system may have changed again or advances in medical treatment may reduce the need for personal care. Increasing income tax rates by 1 percentage point for the over-40s would be a more intergenerationally fair way of raising revenue to pay for social care.

Restricting payments for social care to those aged 40 or over has echoes of Japan's system of long-term care insurance (LTCI). From the age of 40, individuals must pay for LTCI provided by the state. These are banded and related to income – those with the lowest incomes pay half the regular amount, whereas those with the highest incomes pay 1.5 times – so sit somewhere between a regular insurance premium and an income tax. The average monthly premium was £37 in 2016, around 1.5 per cent of the average wage. [56] This has funded an expansion of support for long-term care costs, though there are still co-payments which also vary by income: those with the highest incomes must still pay 30 per cent of their care costs. Co-payments are capped, however, so no one faces catastrophic costs that wipe out nearly all of their assets.

Substituting this age-restricted income tax rise for the mooted rise in employee NICs would mean that those under 40 would not have to contribute towards additional funding for social care. But it would also raise around £1 billion a year less than a rise in employer NICs. We therefore combine this reform with another measure that would affect better-off pensioners, namely means-testing winter fuel payments so that they are only received by those on pension credit. This is in line with the Dilnot Commission's suggestion that the better-off older people who would be the immediate beneficiaries of a cap on care costs should pay at least part of the cost of this measure. This would conform to the principle of social insurance, as this group would be no better or worse off *on average* from the combination of the two changes, but each individual would no longer face the risk of paying very high care costs.

Overall, this package would place the burden of paying for social care much more clearly on older generations: it would be the under-40s who would face a much lower burden of paying for social care rather than pensioners, [57] whereas the elderly would face the largest average loss as a share of their income.

Figure 5 – Increasing income tax for the over-40s and means-testing winter fuel payments would shift the burden of paying for social care to older generations



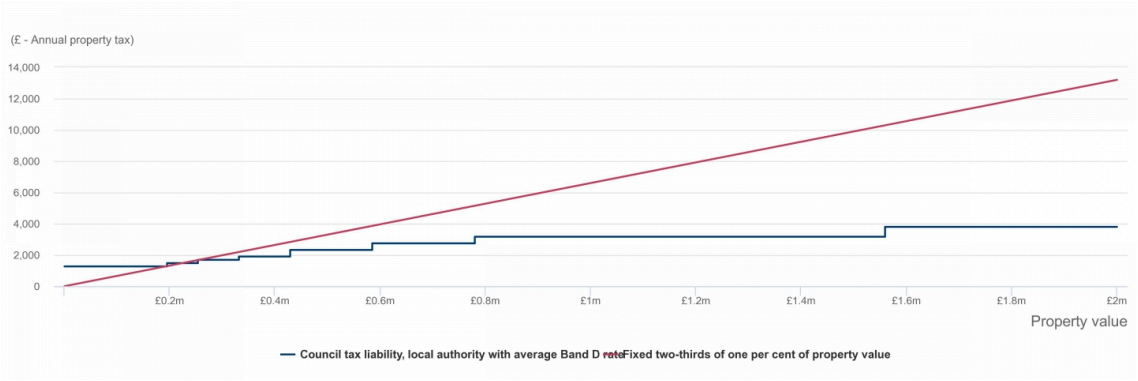
Source: TBI calculations using UKMOD.

This would be a much more intergenerationally fair way to raise revenue to pay for social care. But it is not the most progressive option. Nor does it address existing issues with the tax system. Indeed, since it still involves an increase in employer NICs and for the self-employed, it would increase the difference in tax rates between earned and unearned income further. Both pensioners and those of working age might reasonably feel that the under-taxation of capital gains, pensions, land and property ought to be addressed before raising taxes on workers or raiding pensioner benefits. Our other two options examine reforms in these areas.

Option 2: Replacing Council Tax With a Housing Services Tax

Land and property are undertaxed in the current system, particularly at the higher end. The banded rate structure leads to more and less valuable properties within bands being charged the same tax rate – at the top end, all properties worth more than £320,000 in 1991 are charged the same amount, for example – but more importantly the tax charged in each band does not rise in proportion to the increase in property values (Figure 6). There is little justification for low tax rates for higher-value properties as it reduces both the progressivity and the efficiency of the tax system. Since those who live in higher-value properties also tend to be wealthier and have higher incomes, the rich are the primary beneficiaries of this discrepancy. Moreover, as the supply of land is fixed and so is not affected by taxation, there is a strong case for taxing land and property *more* heavily than labour or capital to minimise the extent to which the tax system distorts economic activity.

Figure 6 – Higher-value properties pay less council tax relative to their value

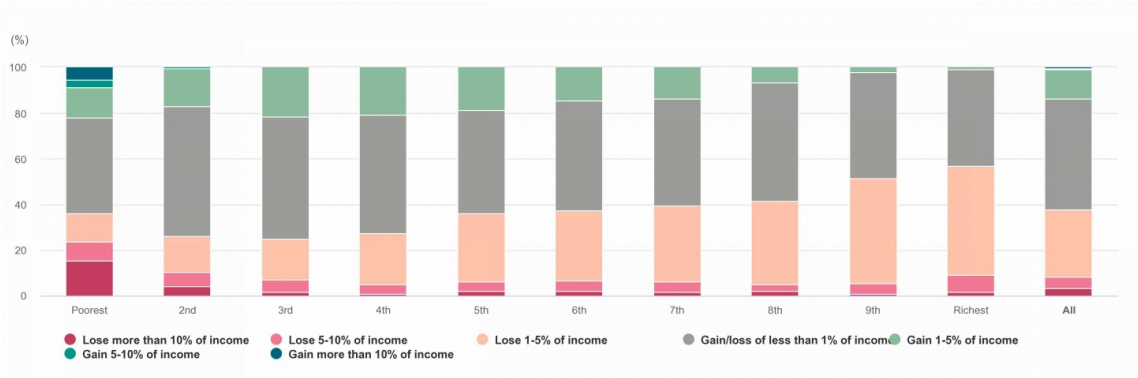


Source: TBI calculations.

We estimate that a housing services tax set at a fixed rate of two-thirds of 1 per cent of property values would increase tax revenues by as much as a 1 per cent rise in all NICs rates. Its impact would be to reduce tax liabilities for those in cheaper properties – broadly, those in council tax Band A at the moment – represent little change for those with property values below the average (Band B properties) and an increase in tax liabilities at average property values and higher.

Again, as those with higher-value properties also tend to have higher incomes, losers would be most heavily concentrated at higher income levels. 57 per cent of the highest-income tenth of households would see their net income fall by 1 per cent or more. But there would also be many asset-rich income-poor losers, many of whom are pensioners: around a third of losers among the lower-income half of households would be pensioners, compared to less than 20 per cent in the higher-income half. This is arguably a positive feature of the policy as homeowning pensioners will be the biggest beneficiaries of proposals to cap care costs even if they had lower incomes. Nevertheless, the political challenge of raising this much money through a housing services tax is substantial and finding a way to mitigate its impact on this group would be an essential part of overcoming it. A partial solution might be to allow pensioners with low incomes and limited other assets to defer payment of tax liability until death or the property was sold.

Figure 7 – Losers from a housing services tax would be concentrated at higher income levels



Note: Modelling follows method of Chapter 16.2.1 of Tax by Design: the Mirrlees Review: existing Council Tax Bands are used to estimate current property value.

Source: TBI calculations using UKMOD.

Another issue that would arise, given the way local government is funded and the massive variation in property values across the UK, is how revenues would be split among local authorities. Introducing a housing services tax would increase the tax base of local authorities in the South East dramatically but do little to help those in the north of England. A recent IFS analysis reveals the scale of these changes. [58] Local authorities in London and the commuter belt would see their tax base increase by more than 20 per cent and those in the north of England falls on a similar scale. Thus, if this reform were introduced without any changes in grant funding to local authorities, those in the north would have to set the tax at a much higher percentage of property values than those in London and surrounding areas, undoing much of the effect of the reform. Indeed, the difference would be extreme in some cases: the tax base would more than double in four London boroughs (Camden, Kensington and Chelsea, Richmond and Westminster) and halve in four northern boroughs (Blackpool, Hartlepool, Hull and Middlesbrough).

Alternatively, if grants were to adjust to compensate, the size of these adjustments would be enormous. The IFS has shown that even if a housing services tax were used to replace council tax on a revenue-neutral basis, 24 local authorities in London and the South East would lose more than 100 per cent of their existing grants (i.e. these local authorities would have to pay money to central government rather than receiving a grant). The link between higher taxes and social-care spending in a particular area would thus be rather weak. The geographical distribution of the tax might provoke opposition in London and the South East – our analysis shows that two-thirds of London households would see their net incomes fall by at least 1 per cent, but winners would outnumber losers in the North East of England – but may be attractive to a government committed to 'levelling up'. Indeed, at least one Conservative MP representing a northern constituency has already advocated a reform along these lines. [59]

A property tax that was set proportional to property values would, then, be a sensible reform. There is a strong case for reform of property taxation that would involve a closer link between tax liabilities and

property values and for higher taxes and increase taxes on higher-value properties in particular. But using it to fill funding gaps for social care would require a rethink of the way local government is currently financed.

Option 3: Reforms to Capital Gains Tax

Taxing labour more to fund social care is problematic for many reasons, and while taxing residential property more makes a lot of sense, the political challenges are likely too large, at least for it to provide a full answer to the social-care funding gap. One alternative that is ripe for reform however is capital gains tax (CGT). Capital gains are less heavily taxed than other forms of capital income: whereas most forms of returns to capital are taxed at income tax rates of 20 per cent, 40 per cent and 45 per cent, CGT rates range from 10 per cent to 28 per cent depending on the source and amount of gains. And with earned income subject to NICs as well, the discrepancy in taxation of capital gains relative to earned income is stark. There is therefore a strong incentive for those who are able to do so to receive remuneration in this form.

Moreover, low rates of tax on capital gains relative to other forms of income are not only a source of unfairness between people with the *same* level of income but a different income composition but also a source of unfairness between richer and poorer groups. Since capital gains are disproportionately received by the very richest – 90 per cent are received by those with total income and capital gains above £100,000 – this disparity in tax treatment is of disproportionate benefit to the better off. [60] Indeed, it lowers the average effective tax rate of those with total income and capital gains of more than £10 million to less than that of the median earner. Bringing the tax treatment of income and capital gains closer into alignment would therefore be a highly progressive, as well as economically efficient, reform.

CGT reform could take many forms and a list of potential changes is in Table 1 below. Aligning income tax and CGT rates is an obvious place to start to create neutrality across different sources of returns to capital. But this is far from the only reform that would be necessary. Currently, there is a separate CGT allowance of £12,300 that cannot be used to offset other forms of income. This means that someone who receives both income and capital gains in a particular year can receive nearly £25,000 without paying any tax, whereas someone who only receives one or the other can only receive half that. Significant sums could be raised if there were only a single allowance that could be used to offset either income or capital gains.

Entrepreneurs' relief, which reduced the CGT rate to 10 per cent for the first £10 million of gains on certain business assets, was reduced in generosity in the 2020 Budget and renamed Business Asset Disposal Relief. Now only the first £1 million of assets qualify. But the justification for its retention at all is weak. There is little evidence that it has any beneficial effects: Encouraging the self-employed to retain

capital in their own businesses does not appear to increase investment [61] and few of the entrepreneurs who may be eligible for the relief in the future are aware of it. [62]

The final revenue-raising measure would remove the forgiveness of CGT at death. At present those who inherit assets only pay CGT on the gains that have accrued since they inherited them. Again, this has little justification. The argument that gains should be forgiven at death because they are subject to inheritance tax is not persuasive since other remuneration on which tax has already been paid is also subject to inheritance tax. Applied to labour income, it would suggest that income tax should be refunded if the income is subsequently bequeathed.

As well as being economically inefficient, it is unfair to levy CGT on purely nominal gains – asset price increases in line with inflation. So this package also includes the introduction of an "indexation allowance". This would uprate the price originally paid in line with consumer price inflation since that point when the gain made on an asset was calculated.

Figure 8 – Capital gains tax reforms could raise significant revenues

Measure	Revenue raised 2023–2024, £ billion
Align CGT and income tax rates	10
Remove separate CGT allowance	7
Remove Business Asset Disposal Relief	4
Remove forgiveness at death	2
Introduce indexation allowance	-8
Total	**16**

Source: IPPR plus TBI calculations to account for reduction in generosity of Business Asset Disposal Relief in Budget 2020. [63]

This package is expected to raise around £16 billion in 2023–2024, significantly more than the mooted 1 per cent rise in all NICs rates. Some of the additional revenue could be used to mitigate potential undesirable impacts of the package. For example, it may be desirable to retain a small CGT allowance (of, say, £1,000) to reduce the administrative burden on those who realise small amounts of capital gains. [64] Second, it would be desirable to maintain some form of incentive for certain groups of highly mobile

entrepreneurs, such as founders of tech startups, to encourage them to locate in the UK. But this should be much more tightly-targeted than Business Asset Disposal Relief is currently.

The biggest problem of using CGT to pay for social care is political. It lacks the clear link between the tax rise and additional funds for social care that is more apparent with a NICs rise or a specific income tax levy. It is not immediately obvious why the less than 300,000 people who pay capital gains tax each year should bear the sole burden of paying for a better social care system, for example. [65] But that these individuals are currently unfairly benefiting from disparities in the tax system that should be addressed irrespective of the need to fund social care. It is merely a happy coincidence that the revenue raised would approximately cover the cost of a comprehensive package for fixing social care.

Insurance Payments or a Notional Social-Care Savings Account as an Alternative Funding Mechanism?

Are there alternatives to tax funding for social care, though? Two other alternatives might be private insurance or encouraging greater private saving so that individuals will be able to pay for care without having to sell their homes. But we have already seen that private-insurance markets are poorly developed in all OECD countries, partly because it is hard to know how expensive care will be many years hence and partly because of myopia on the part of consumers. And people would presumably prefer to save a little over their working lives to pay for the cost of insurance against high care costs rather than save much more in case they have to pay for care later on. Nevertheless, some form of state-run insurance scheme that involved paying a one-off premium to cover all subsequent care costs, or combining compulsory saving to pay for costs up to a cap with insurance against high care costs might both be solutions that are worth examining.

One-Off Insurance Payment

A one-off insurance-style payment to the state is a solution that interested both major political parties before the 2010 general election. The Conservatives proposed a voluntary one-off payment of £8,000 from every pensioner on retirement in return for free residential care, whereas Labour proposed a larger charge that would cover all social care that could be deferred until death.

Since then, however, the idea has largely faded from attention, though it was revived in a recent paper by Lord Lilley. [66] Lilley proposes that the government should offer those reaching state pension age fairly priced insurance to protect their assets from being used to pay for social care. Those who purchased this insurance would not have to use their assets to pay for care, whereas those who do not would remain under the existing means-tested system.

By definition, of course, this would do nothing to improve the quality of the existing means-tested system. Premiums paid by those who opted for insurance (who would presumably be homeowners, though perhaps not the very wealthy) would only cover payments that are currently made by self-payers, if the insurance was actuarially fair as Lilley proposes. There would be nothing left over to pay for more care for those who are unable to pay, which as we have seen represents the bulk of the cost of reform. So any such proposal only tackles one aspect of the challenges facing social care.

Moreover, similar proposals have swiftly run into political difficulties in the past. The Conservatives campaigned against Labour's "death tax" and did not pursue their own proposal in the coalition government. Nor do other countries fund social care in this way, and the small size of the private-insurance market in all OECD countries suggests that there would be little interest in voluntary payments in any event. [67] If insurance were made compulsory, this would likely by very unpopular: in deliberative workshops where people were asked to consider this issue, people felt that contributions should be linked to ability to pay. [68]

This idea comes closest to an insurance model against high care costs and avoids the objection to the Dilnot proposals that they involve subsidising the care of the wealthy who could afford to pay for it themselves. But introducing such a scheme on a compulsory basis seems extremely challenging politically and introducing on a voluntary basis is likely to lead to low take-up. It also does little to improve the system for those unable to pay: tax rises would still be required to stabilise the current system and improve staff pay.

Notional Social-Care Account

An alternative to compulsory insurance against high care costs is compulsory saving to pay for care. One way in which this could be done is through a notional savings account whereby individuals would be obliged to make a contribution out of their income each year into an account held with the government. The funds held in this account could only be used to pay for social care. For those who did not end up using social care, or who retained a positive balance at death, the remaining funds would form part of their estate and could be distributed to their heirs. Contributions to care costs could be capped at an individual's account balance, providing a limit to out-of-pocket contributions as in the Dilnot proposals. Given that current older people would not have made any or only very small contributions, this feature could be phased in over time so that those who had not made significant contributions to their accounts would have to pay costs out of their income or other assets up to a cap that reduced over time.

There are several potential advantages to this proposal. First, it might be more politically feasible as it does not involve higher taxes. It might also raise fewer objections from those who would not benefit from higher social-care spending because they would choose to be cared for by family members. And by running the system on a "pay as you go" basis – that is, using contributions to finance immediate care

needs rather than setting them aside – it would provide funds for social care immediately, unlike proposals that sought to stimulate insurance or savings products in the private market.

That said, there are also good reasons why a tax-funded solution might be preferable. As with proposals to encourage private saving to pay for care costs in later life, a notional savings account would not by itself provide people with insurance against high care costs: rather, everyone would have to save to cover the possibility that they might need to pay out in later life. Given the choice between paying a small tax that pools risk rather than a larger contribution to an account that could not be accessed in their lifetime, people may prefer the former. But equally they may not: there is some evidence that older people do not spend down their financial assets in retirement, suggesting that bequeathing assets to their children is a significant motivating factor. [69] In this case, compulsory saving in a notional account would for many people simply replace saving they would have done anyway.

From the perspective of the public finances, the only difference between a tax to fund social care and this PAYG scheme is that they would have to make payouts to those who retained positive account balances to the end of their life. Since tax revenues grow over time as the economy grows, repayments in any period would be less than contributions being paid in even if everyone received back their contributions in full. (This assumes that account balances would be credited with interest at a rate that was lower than the long-run growth rate. [70]) Further savings could be made by imposing inheritance tax on transferred account balances: as the funds in the account could not be transferred to heirs before death, there would be no way of avoiding the tax.

The extent to which these benefits and problems will arise would depend on the precise design of the system. Although designing a scheme is beyond the scope of this paper, the level of contributions and the rate of return offered on account balances would clearly be key parameters. If contribution rates were too low, there would not be enough revenue raised; too high and the scheme would not provide any insurance for the better off, who would be highly unlikely ever to be exhaust their account balances. Similarly, if the rate of return on account balances was too small, the compulsory saving would become closer to a tax – given that there would be a long time between the first contributions being made to the account and payouts at death, inflation could erode their value considerably. If the interest rate were too high, however, the cost of paying out balances at the end of life would be high. Indeed, as discussed above unless account balances earned interest at a rate lower than growth in the economy, there would be no benefit to the public finances from those who never used social care participating in the scheme as the payouts at the end of life would be no smaller than the contributions paid in relative to the size of the economy.

On balance, it would be hard to argue that notional accounts to pay for social care are superior to tax financing. Setting up such a system runs the risk of creating a system that will become largely redundant if advances in medical care reduce the need for social care in the future: people will have saved

unnecessarily. But in a situation where there has been little progress on finding a sustainable funding source for social care for the past 25 years, other options surely merit consideration.

Summary

The government has mooted a 1 per cent increase in all NICs rates to pay for additional funding for social care. This is a straightforward increase of an existing tax that we can be reasonably confident will meet the most pressing needs of the existing social-care system and provide some insurance against catastrophic care costs. Similar NICs rises in 2003 and 2011 demonstrate that reforms along these lines are politically feasible in the right circumstances.

However, this approach is not without problems, either political or economic. Cabinet ministers have already expressed unease with breaking a manifesto commitment not to increase headline NICs rates. Opposition among the public may grow once they realise that working-age people would be asked to bear the entire burden of funding improvements in a service they are unlikely to directly benefit from many years to come, if at all, whereas the elderly will benefit without having to make any contributions. And increasing NICs widens existing inequities in the tax system between the treatment of earned and unearned income, and in the treatment of the employed and self-employed.

Alternative approaches to funding social care that would be more intergenerationally fair and more progressive include an income tax increase for the over-40s, replacing council tax with a tax that was proportional to property values and reforms to capital gains tax. Other options that involved insurance or compulsory saving could also form part of the solution. None of these are without political difficulty either, however. Given the difficulties that have been experienced in finding a sustainable funding source for social care, a process leading to cross-party consensus on the way forward may be necessary. This would involve the creation of a commission made up of senior politicians from all main parties to consider the issue. Previous efforts to achieve cross-party consensus before the 2010 general election, in 2012 and as proposed in March 2020 before the pandemic struck have failed; however, now there is already a broad consensus on what is needed to solve the problem, agreement on a funding solution may be possible as occurred on pensions in the mid-2000s.

Conclusion

The social-care system is in a bad state. A decade of austerity for local government has left many of those who require it with unmet need for care, providers unable to meet their costs and staff leaving the sector as pay falls behind levels of other occupations. Improvements in health at older ages have not been sufficient to offset growing demand from a larger elderly population and from working-aged disabled adults.

In the short term, increased funding is needed to stabilise the system and ensure that it is able to meet the need that exists and increasing demand from both the elderly and the working-age disabled as well as giving greater support to family carers. This is the immediate priority for the years ahead. Higher wages for care workers may also be needed if unemployment falls back quickly post-Covid or local workers are not prepared to take on jobs that have previously been filled by migrants from the EU post-Brexit. And there is a strong case for a greater degree of social insurance against catastrophic social-care costs. This could follow the Dilnot Commission's proposals, a more progressive variant that capped costs as a percentage of total assets, or through voluntary insurance.

This will be expensive. The total cost of filling gaps in the existing system, increasing staff pay to levels in line with equivalent NHS staff and introducing a cap on care costs would be £14 billion a year. To succeed where previous efforts have failed, policymakers will have to think carefully about how to fund these reforms.

In the longer term, however, advances in medical care might reduce the need for social care. Any reforms must not make assumptions that demands for social care will be the same in twenty years' time. This means that policymakers should avoid locking in policies that cannot easily be adjusted to changing circumstances or impose taxes on younger generations to pay for services that they may not ultimately require.

The government appears to want to press ahead with a 1 per cent rise in all NICs rates. However, this would place the entire burden of funding on working age people, who will mostly not benefit from this spending for a long time to come, if at all. It would also exacerbate existing problems in the tax system, increasing the tax rate on earned income, especially that from employment. Other fairer and more economically efficient alternatives should be considered, including an income tax rise for the over-40s, replacing council tax with a tax that was proportional to property values and reforms to capital gains tax. None of these are without political difficulties, but nor is taxing young workers to pay for the care of the wealthy. Given the political challenge of finding a sustainable funding source for social care, it may require renewed effort to build cross-party consensus to agree a way forward, particularly as there is now broad agreement on what is required.

Social care has long been neglected, but the failures in the system that have become apparent during the course of the Covid-19 pandemic make this an opportunity for reform. By coming together to address an issue on which there is already broad consensus, policymakers have a chance to make a real difference to the lives of many vulnerable people.

Charts created with Highcharts unless otherwise credited.

Footnotes

1. ^ Henry Zeffman, “Don’t Raise National Insurance to Pay for Social Care, Says Kwasi Kwarteng ,” The Times, July 22, 2021, https://www.thetimes.co.uk/article/keir-starmer-attacks-jobs-tax-for-social-care-jmfqqvdv9.
2. ^ We discuss the means test in more detail in the following section.
3. ^ OECD, Help Wanted? Providing and Paying for Long-Term Care, 2011, https://doi.org/10.1787/888932401653.
4. ^ Source: Adult Social Care Activity and Finance Report, England - 2019-20, https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20/appendix-b.
5. ^ See Institute for Government, ‘Adult social care performance tracker, 2019’, https://www.instituteforgovernment.org.uk/publication/performance-tracker-2019/adult-social-care.
6. ^ Eric Emerson and Susannah Baines, “Health Inequalities and People with Learning Disabilities in the UK,” Tizard Learning Disability Review 16, no. 1 (2011), https://doi.org/10.5042/tldr.2011.0008.
7. ^ Simon Bottery and Gbemi Babalola, “Social Care 360,” The King’s Fund, 2020, https://www.kingsfund.org.uk/publications/social-care-360
8. ^ Bottery and Babalola.
9. ^ Source: Adult Social Care Activity and Finance Report, 2019–2020.
10. ^ James Caiels, Alisoun Milne, and Julie Beadle-Brown, “Taking a Strengths-Based Approach to Social Work and Social Care: A Literature Review,” Discussion Paper, February 2021.
11. ^ Source: Adult Social Care Outcomes Framework 2019–20.
12. ^ Think Local Act Personal, “Direct Payments: Working or Not Working?,” 2020.
13. ^ https://www.who.int/data/gho/data/indicators/indicator-details/GHO/gho-ghe-hale-healthy-life-expectancy-at-birth
14. ^ See for example https://www.bbc.co.uk/news/technology-58317106
15. ^ James Wright, “Technology in Social Care: Review of the UK Policy Landscape,” Sustainable Care Paper, 2020, http://circle.group.shef.ac.uk/wp-content/uploads/2020/11/2020_Hamblin_Technology-in-social-care_SC-Paper-2_Nov-20.pdf

16. ^ Hugh Alderwick, Charles Tallack and Toby Watt, "What Should Be Done to Fix the Crisis in Social Care? Five Priorities for Government," 2019, https://www.health.org.uk/sites/default/files/2019-08/20190410-What-should-be-done-to-fix-the-crisis-in-social-care.pdf
17. ^ Competition and Markets Authority, "Care Homes Market Study: Final Report," 2017, https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf
18. ^ David Bell, "Free Personal Care: What the Scottish Approach to Social Care Would Cost in England," Health Foundation Newsletter, May 30, 2018, https://www.health.org.uk/newsletter-feature/free-personal-care-what-the-scottish-approach-to-social-care-would-cost-in
19. ^ Alderwick, Tallack and Watt, "What Should Be Done to Fix the Crisis in Social Care? Five Priorities for Government."
20. ^ David Bell, Alison Bowes and Alison Dawson, "Free Personal Care in Scotland," 2007, https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/2075-scotland-care-older-people.pdf
21. ^ Independent Age, "Free Personal Care: Insights from Scotland," 2020.
22. ^ Omar Idriss et al., "Social Care Funding Gap," The Health Foundation, February 11, 2021, https://www.health.org.uk/news-and-comment/charts-and-infographics/REAL-social-care-funding-gap
23. ^ Ipsos Mori, Understanding Public Attitudes to Social Care Funding Reform in England Report Prepared for the Health Foundation, 2018, http://www.ipsos-mori.com/terms.
24. ^ Ben Hewitson, Becky Seale and Lucy Joyce, "Public Engagement Exploring Care and Support Funding Options," 2011.
25. ^ We would propose that the existing means test be retained alongside this proportional cap. Those with few assets would still not have to make any contribution towards their care costs, and those with slightly higher asset levels would quickly hit the cap in any event.
26. ^ See Table 2.11, ONS "Total Wealth: Wealth in Great Britain", https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/incomeandwealth/datasets/totalwealthwealthingreatbritain
27. ^ Peter Lilley, "Solving the Social Care Dilemma? A Responsible Solution," 2021, https://www.civitas.org.uk/content/files/SOCIAL-CARE.pdf

28. ^ Given that domiciliary care users would still need somewhere to live, the charge would be deferred until death or the sale of the property for this group.
29. ^ Age UK, "Estimating Need in Older People," 2019, https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/active-communities/id204303-estimating-needs-report.pdf
30. ^ Richard Humphries et al., "Social Care for Older People: Home Truths," 2016.
31. ^ See https://www.leonardcheshire.org/sites/default/files/2019-03/social_care_briefing_-_leonard_cheshire.docx
32. ^ Source: State of Care, Care Quality Commission, 2020, https://www.cqc.org.uk/publications/major-report/state-care
33. ^ Source: NHS Digital, Personal Social Care Services Adult Social Care Survey.
34. ^ Source: NHS Digital, Adult Social Care Outcomes Framework.
35. ^ Source: https://www.health.org.uk/news-and-comment/charts-and-infographics/REAL-social-care-funding-gap
36. ^ Raphael Wittenberg, Bo Hu and Ruth Hancock, "Projections of Demand and Expenditure on Adult Social Care 2015 to 2040," PSSRU Discussion Paper, November 2018, https://www.pssru.ac.uk/publications/pub-5421/
37. ^ ADASS, "ADASS Budget Survey 2019," accessed January 13, 2021, https://www.adass.org.uk/media/7295/adass-budget-survey-report-2019_final.pdf
38. ^ Source: Public Health England.
39. ^ Laura Jefferson et al., "Home Care in England: Views from Commissioners and Providers," 2018, https://www.kingsfund.org.uk/sites/default/files/2018-12/Home-care-in-England-report.pdf
40. ^ Idriss et al., "Social Care Funding Gap."
41. ^ Bottery and Babalola, "Social Care 360."
42. ^ Anita Charlesworth and Toby Watt, "The Real Cost of a Fair Adult Social Care System ," Health Foundation, 2019, https://www.health.org.uk/news-and-comment/blogs/the-real-cost-of-a-fair-adult-social-care-system
43. ^ Source for all figures in this paragraph: Skills for Care, "The State of the Adult Social Care Sector and Workforce in England," 2020, https://www.skillsforcare.org.uk/adult-social-care-

workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx

44. ^ Skills for Care.
45. ^ Marley Morris, "Building a Post-Brexit Immigration System for the Economic Recovery," 2020, https://www.ippr.org/files/2020-11/post-brexit-migrationnov20.pdf
46. ^ Charlesworth and Watt, "The Real Cost of a Fair Adult Social Care System ."
47. ^ Source: Personal Social Services Survey of Adult Carers in England, 2018–19.
48. ^ Carers UK, "Carers at Breaking Point: Making the Case for Carers' Breaks in England," 2019, https://www.carersuk.org/images/News__campaigns/GiveUsaABreak_Aug19_FINAL.pdf
49. ^ Source: ONS Population Projections, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/nationalpopulationprojections/2018based
50. ^ Linda Pickard, "A Growing Care Gap' the Supply of Unpaid Care for Older People by Their Adult Children in England to 2032," Ageing and Society 35, no. 1 (2015): 96–123, https://doi.org/10.1017/S0144686X13000512
51. ^ Wittenberg, Hu and Hancock, "Projections of Demand and Expenditure on Adult Social Care 2015 to 2040."
52. ^ Natasha Curry, Sophie Castle-Clarke and Nina Hemmings, "What Can England Learn from the Long-Term Care System in Germany?," Nuffield Trust, 2019, https://www.nuffieldtrust.org.uk/research/what-can-england-learn-from-the-long-term-care-system-in-germany
53. ^ We use UKMOD version A.2.5.1 for our analysis. UKMOD is maintained, developed and managed by the Centre for Microsimulation and Policy Analysis at the Institute for Social and Economic Research (ISER), University of Essex. The process of extending and updating UKMOD is financially supported by the Nuffield Foundation.
54. ^ James Browne, "Principles of Tax Reform: A Post-Covid Opportunity to Build a Fairer System," 2021, https://institute.global/sites/default/files/articles/Principles-of-Tax-Reform-A-Post-Covid-Opportunity-to-Build-a-Fairer-System.pdf
55. ^ Stuart Adam and Helen Miller, "Taxing Work and Investment across Legal Forms: Pathways to Well-Designed Taxes," IFS Report (Institute for Fiscal Studies, 2021), https://doi.org/10.1920/RE.IFS.2021.0184

56. ^ Natasha Curry, Sophie Castle-Clarke and Nina Hemmings, "What Can England Learn from the Long-Term Care System in Japan?," 2018, https://www.nuffieldtrust.org.uk/files/2018-06/learning-from-japan-final.pdf

57. ^ Younger people would still lose out in two respects. First, the self-employed would still face an increase in NICs. Second, as employer NICs would still be increased, this may be passed on to employees in the form of lower wages.

58. ^ Stuart Adam et al., "Revaluation and Reform: Bringing Council Tax in England into the 21st Century," 2020, https://www.ifs.org.uk/uploads/R168-Revaluation-and-reform-bringing-council-tax-in-England-into-the-21st-century-updated.pdf

59. ^ https://www.conservativehome.com/platform/2021/02/john-stevenson-property-tax-reform-is-key-to-levelling-up-the-country-and-the-conservatives-electoral-chances.html.

60. ^ Andy Summers and Arun Advani, "How Much Tax Do The Rich Really Pay And Could They Pay More?: New Evidence from Tax Microdata in the UK," CAGE Policy Briefing, 2020, https://warwick.ac.uk/fac/soc/economics/research/centres/cage/manage/publications/bn27.2020.pdf

61. ^ Helen Miller, Thomas Pope and Kate Smith, "Intertemporal Income Shifting and the Taxation of Owner-Managed Businesses," Institute for Fiscal Studies Working Paper W19/25 (2019), https://doi.org/10.1920/wp.ifs.2019.1925

62. ^ IFF Research, "Capital Gains Tax Entrepreneurs' Relief: Behaviours and Motivations," HMRC Research Report, 2017, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/663877/HMRC_Report_456_CGT_ER.pdf

63. ^ Shreya Nanda, "Reforming the Taxation of Income from Wealth," 2019, https://www.ippr.org/files/2019-11/capital-gains-tax-briefing.pdf

64. ^ The IPPR recommend this as part of their package, but do not attempt to cost it, claiming that the revenue impact would be small. See Shreya Nanda and Henry Parkes, "Just Tax: Reforming the Taxation of Income from Wealth and Work," 2019, https://www.ippr.org/files/2019-09/just-tax-sept19.pdf

65. ^ Source: HMRC Statistics, Numbers of Taxpayers and Registered Traders, https://www.gov.uk/government/statistics/numbers-of-taxpayers-and-registered-traders

66. ^ Lilley, "Solving the Social Care Dilemma? A Responsible Solution."

67. ^ OECD, Help Wanted? Providing and Paying for Long-Term Care.

68. ^ Ipsos Mori, Understanding Public Attitudes to Social Care Funding Reform in England Report Prepared for the Health Foundation.

69. ^ Rowena Crawford, "The Use of Wealth in Retirement," IFS Briefing Note, BN236 (2018).

70. ^ This is the famous r<g condition, which is important for the sustainability of public debt: when interest rates on government borrowing are lower than the growth rate, it means that public debt remains sustainable as debt will accumulate less quickly than the economy grows.

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