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A better future for adult social care

Dignity, independence and fairness for older adults who receive social care and those who provide it

December 2018

A call for change

The imminent green paper on adult social care is an opportunity to galvanise change. And change is needed. Politicians, a whole array of policy papers, and participants in the sector all agree on that. But do our political leaders have the stomach for the challenge?

It would not be the first time they've ducked this. Going back over 20 years to a Royal Commission launched in the first year of Tony Blair's leadership, Governments of all hues have largely failed to adopt meaningful, positive reform.

Put simply, if children were treated the way some of our older adults are we would not tolerate it as a society. The reality is that too many suffer at the hands of a system that is underfunded, fragmented and in some places essentially broken.

It is not all doom and gloom. As set out in the Local Government Association (LGA) green paper, the industry itself has driven efficiencies and innovations which have led to improved outcomes across a range of measures. However, you do not have to move far before you hear heart wrenching tales of how the system overall has failed those who need our help most.

The purpose of this paper is to provide context and analysis on what is happening in this vitally important sector. It is of fundamental importance to many millions of adults who require support in living their lives. It also affects the c1.5 million paid employees, and nearly 8 million family carers who provide the equivalent of around 4 million full-time jobs worth of support to those they care for. Unpaid care is worth well over £100bn pa to the economy; it is of a comparable scale to the entire NHS.

Everyone aspires to grow old. For a large proportion of us that do reach four score and ten, we'll need some level of help and support to live our later years. Within the decade we will reach a tipping point where a typical pensioner is more likely to see 90 than not according to Club Vita; there will be increasing numbers surviving to much older ages. The Department of Health and Social Care suggests that the number of full-time equivalent jobs would need to increase at 2.6% each year until 2035 to meet increasing demand from these demographic shifts. The green paper provides a focus for us to improve that support, so the future is more dignified, more independent and more fulfilling for everyone.

We look forward to engaging in the debate, seeking to improve the system, and securing a better future for some of the most vulnerable in our society.

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Adult social care – the action needed

By Government

- Set up a statutory office for health and social care
- Engage with and be clearer with the public on the system today and the changes required
- Deliver a sustainable funding policy for the long term based on more funding from the private sector
- Focus on prevention and joining up people centred health and social care

By insurers

- Build on implementation of a cost cap to develop attractive care products
- Engage with the technology sector to finance and develop better prevention
- Work with Government to help individuals save for their own care

By Local Authorities and NHS

- Continue to innovate, both to improve outcomes for individuals and manage costs
- Keep disseminating best practice and work positively on prevention
- Drive towards closer and better integrated services for people

By individuals

- Continue to care for friends and family; the system depends on it
- Actively participate in the conversation about the changes needed and recognise the challenges we face today
- Recognise the need to use more of your own funds to pay for care – whether that's saving while working or spending existing wealth

Adult social care – why we need action?

People face potentially catastrophic costs:

1 in 10 adults reaching age 65 will face costs of **more than £100k** to pay for care. (Source: Dilnott)

Less available funding for more people needing care:

Social care funding dropped by 11% yet the number of adults over 65 has increased by 18% (Source: IFS)

Friends and family are already taking the strain:

2/3 of care already delivered informally by friends and family

Care home sector is struggling:

148 care homes ceased trading last year

Demand for care is only going to rise:

there will be 50% more adults over 85 by 2041

Very few individuals are providing for care needs:

42% of adults don't expect to ever save for care

Adult social care today

> In the words of the Communities and Local Government select committee, the adult social care system is under unsustainable strain. It is not fit to respond to current needs, let alone predicted future needs as a result of demographic trends.

We see six key challenges which reform must tackle:

1. **Care must be improved.** Some vulnerable adults are living their lives in a way we would not tolerate for our parents or grandparents. If sufficient light was shone on the issue, the calls from the public for change would become too loud to ignore.

2. **Austerity in the sector** is damaging many thousands of individuals' lives. Funding via local authorities must increase. Since 2010, funding has dropped 8% in real terms despite the number of adults aged over 65 increasing by 18%, according to the IFS[1]. We need a long term sustainable funding solution.

3. **Encouraging funding from the private sector.** The general public do not understand the system, and most have a rude awakening when they find out that many of the symptoms of growing old are not treated by the NHS. Without understanding there is no incentive to save. Without a working insurance market, there are catastrophic costs for some and no risk sharing for society. The costs of fixing the system will be high, and private sector capital and investment will be crucial to making them politically tolerable.

4. **The care workforce is under strain.** The private sector, third sector and family carers are all facing challenges. The price paid by local authorities in many areas has been driven so low it is below the operating cost of provision. For large operators, people paying for their own care are paying in the region of 40% more than local authority funded clients. While this might appear efficient in the short term, it cannot continue in the long term. The risk of more 'Southern Cross' disasters is high, with 148[2] care homes ceasing trading in the last year alone. The stress on adults in care who need to be moved, and on their families, is very high leading to a serious deterioration in health in many cases.

5. **Gaps and inconsistencies between the NHS and social care.** Despite progress, meaningful gaps remain. Insufficient spending on primary, community and social care increases the costs of acute hospital care. The current approach does not make sense. People's needs will be best served by an integrated experience that is focussed on delivering them the best possible care. Integrated governance and commissioning that is locally accountable and targeted is the best way to achieve this.

6. **Demographics.** These are against us on several fronts. Firstly the number of adults of all ages needing care is rapidly rising. For instance, there will be 50% more adults over age 85 by 2041. Also, over two thirds of care is delivered 'informally' by friends and family. Yet not only was the baby boomer generation a large one, it had relatively few children. According to ONS, the ratio of over 75s to adults under 75 will broadly halve over the coming few decades. This bodes poorly for the provision of informal care.

So reform will be hard. Transparency will be needed to generate the public will for change. That will be unwelcome for many, mostly because they do not realise the extent of the problems we have. But it is now necessary for us all to grasp this nettle, and start building a better future.

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[1] Public spending on adult social care in England. IFS Briefing Note BN200.

[2] http://www.carehomeprofessional.com/care-home-insolvencies-soar-83-2017-18/

What we need to change

To deliver a better system we need: cash; capacity and coordination.

Cash

There are no two ways about it, the system needs more money. It needs a healthy injection now, and yet more in the years to come. Taxation of current and future generations will be needed. This is never going to be popular, but the case for change is clear to those who are familiar with the issues. The money also needs to be spent well. Prevention should be prioritised, both to improve individuals' lives and to manage down the total cost faced by wider society.

We do feel strongly that the Dilnot 'partnership' funding model of both private and public sector contributions has much to commend it. Social care costs are society's largest mainstream uninsured risk. There's no reason for it to be this way. Even without changing the cost of care, there are significant benefits to sharing the costs more evenly across society. Insurance is the route to do so, and it can halt the catastrophic care costs that afflict the unlucky. Back in 2011, the Dilnot Commission estimated that 1 in 10 adults who reached age 65 would faces costs in excess of £100,000. These numbers will only have increased since then.

Capacity

Money can't buy you love, nor can it fix a system of this scale alone. The combined health and care industries rely on over 6 million paid and unpaid people – that's around 1 in 10 of us. Planning and building the capacity to support those who need it is the work of many years. Austerity has squeezed capacity from the system, and will be a key contributor to the 6.6% vacancy rate and 27.8% staff turnover rate in 2017/18 according to the National Audit Office (NAO).

Local authorities have the responsibility for market shaping, and with adequate funding they will also have the means. To do so effectively, they have to work seamlessly with the health services. Our current fragmented organisational structures don't allow them to do that easily.

Coordination

As highlighted by the Care Quality Commission (CQC), the current system can no longer effectively meet the needs of increasing numbers of older people with complex health and care needs. To deliver the quality of service we would all aspire to takes multiple organisations working seamlessly together. That is a challenge at the best of times. When the organisations themselves are starved of funding and driven by centrally controlled performance targets it is impossible.

People want personalised care, tailored to their individual needs, circumstances and aspirations. Many working in the system want to deliver that.

What we need from the Green Paper and politicians is a framework that allows this to be delivered. It will be a framework that pulls organisations together. It will be a framework that supports more health and care delivered in the community. And it will be a framework that supports locally targeted, coordinated, decision making and prioritisation.

The view from the International Longevity Centre (ILC):
The crisis in our social care workforce

> The crisis in our social care system is often understood through the narrow lens of its funding system, but our social care system is nothing without a viable workforce.

In 2018 the National Audit Office likened the situation of the social care workforce to a "Cinderella service – without a valued or rewarded workforce".[1] Considering this context, it is perhaps unsurprising that the sector has seen an increase in its vacancy rate in the past 5 years.[2]

This trend reflects the dynamics at play within the care sector; the majority of those who leave a job in adult social care leave the sector altogether (60%), and staff turnover is running at 31% across all jobs and 35% for those working in frontline care.[3]

Recent ILC research has demonstrated that the recruitment issues facing adult social care providers will be further exacerbated by the UK's decision to leave the European Union.[4] Approximately one in twenty social care workers currently come from the EEA, far more than from outside the EEA. If the UK leaves the EU and pursues a low immigration policy (as seems likely at present), then the gap in the social care workforce could reach over 750,000 by 2037.

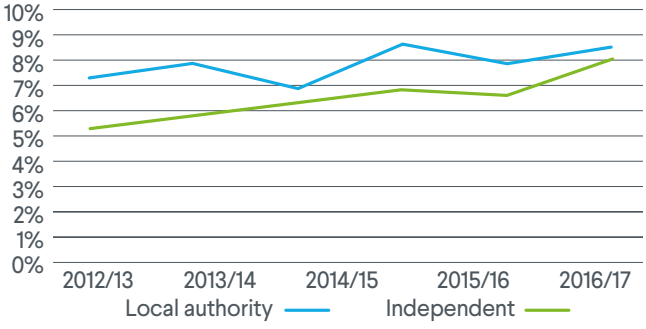
Clearly urgent action is needed to make jobs in the care sector an attractive option for workers both at home and abroad.

However, these vital workforce issues remain unaddressed while policy makers agonise over the future funding settlement for care.

While the long-promised future workforce strategy may offer some ways forward, when it finally emerges, the lack of joining up between funding and workforce agendas is worrying.

A future funding settlement for care developed in isolation from the vital question of how to ensure care work is attractive, is unlikely to be equal to the challenge of creating a care system fit for our ageing society.

Vacancy rate trend - all job roles



[1] NAO (2018) The adult social care workforce in England Accessed at: https://www.nao.org.uk/report/the-adult-social-care-workforce-in-england/

[2] Source: Skills for Care (2018) Workforce estimates

[3] Ibid.

[4] ILC / Independent Age (2016) Brexit and future of migrants in the social care workforce Accessed at: https://ilcuk.org.uk/wp-content/uploads/2018/10/Brexit-and-the-future-of-migrants-in-the-social-care-workforce.pdf

Dan Holden
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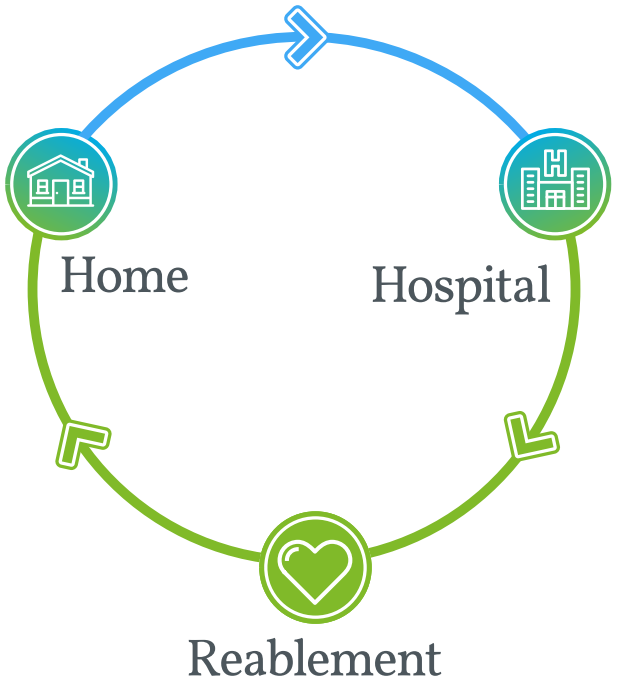
International Longevity Centre

People centred care

The nature and quality of care has a massive impact on happiness, health and longevity. People centred care is about giving those who need support the ability to live, and in the end die, in the way that they want. From the perspective of the overall care system, It is more cost effective, and what most people want, to support people to remain living in their communities for as long as possible.

There is a strong alignment of interests between the needs of the State in controlling costs and the desires of people in need of care. Yet the health and care system whose overall architecture was designed in 1948 struggles to deliver what's required.

Older people who suffer from poor health or a care need can end up in hospital; a good outcome is if they are able to return to their communities. Too often this is not the case.



It is better for all if the blue flow in the diagram above from home to hospital is reduced to be as low as possible. Hospital treatment is expensive, and can age people rapidly due to a lack of exercise and exacerbating loneliness, for example. Hospitals were typically designed to meet acute health needs, not long term care needs. Across the country hospitals are operating far above their optimal capacities. Practical actions to improve the overall health and care system would be greater investment in prevention and early intervention in people's journeys.

Reablement is about avoiding 'delayed transfers of care' and getting people out of hospital as soon as possible once they're ready. More investment in reablement and better coordination with community care will increase the number of people able to return home long term. This will reduce the number who end up as long term residents in geriatric wards or residential care homes.

There are lots of examples across the country of what good primary and community care looks like. It is in this setting that we are learning how to deal with comorbidities and fragile old people, not single issue acute care which hospitals were developed for.

Local authorities in Scotland experienced higher net costs when free personal care was introduced. And, provision of free personal care has become more expensive over time. But looking at these costs in isolation ignores the fact that this provision has helped reduce the number of hospital admissions and the need for residential care. Overall, total government net expenditure could be lower.

People centred care is ultimately about providing dignity and independence for older people who need our help.

The view from the Care Quality Commission:

The need for more collaboration in the delivery of health and care

CQC's annual *State of Care* report highlights that access to good care is increasingly dependent on how well local health and care systems work together.

Our ratings show that overall, quality has been largely maintained from last year, despite continuing challenges around demand, funding and significant workforce pressures across all sectors. But not everyone is getting good care; 40% of NHS acute hospitals require improvement on safety, with pressure on emergency departments particularly visible.

Alongside our rating of providers, CQC focused on people's experience of accessing health and care services – and it is clear that these experiences are often determined by how well local health and care systems work together.

Our reviews of local systems found that ineffective collaboration between services affects access to care and support services in the community, which in turn leads to increased demand for acute services. It means a struggling acute hospital can be symptomatic of a struggling local health and care system, indicating that there are geographical areas where people are less likely to get good care.

The fragility of the adult social care market continues to cause concern, with providers ceasing to trade and contracts being handed back to local authorities. The impact of the NHS funding announced in the summer of 2018 – along with the recent short-term crisis funding announced for adult social care – risks being undermined by the lack of a similar long-term funding solution for social care.

Good, personalised, sustainable care is no longer just about whether individual organisations can deliver good care, but whether they can successfully collaborate with other services as part of an effective local system. Addressing the local system challenge means pooling resources, sharing technology and leadership at all levels that ensures common goals and trust between services.

The alternative is a future in which people's care needs are not met and public money is spent ineffectively.

Chris Day
Director of Engagement
Care Quality Commission (CQC

The crisis in Local Authority funding of social care

5,000 Britons asking for LA help every day

(Source: NHS Digital)

Local authority spending as % of budgets

Number receiving long-term help from local authorities

Number of new requests for social care

38p in every £1 spent by councils last year was on adult social care

LA funding by individual.

This has dropped by 11% per adult

Need an extra:

£6bn p.a. by 2021

£15bn p.a. by 2031

to revert to 2009/10 levels

(Source: Kings Fund)

1.2m adults with unmet care needs (Source: ADASS)

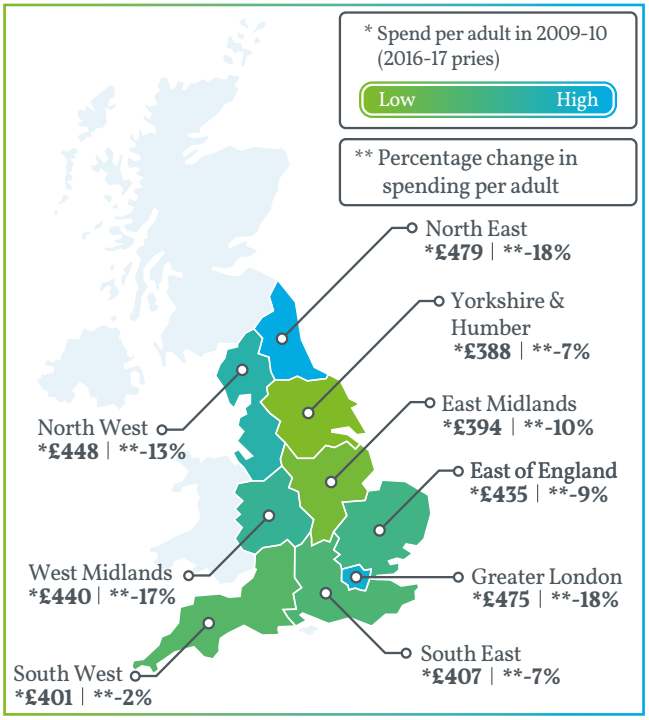
The current state of funding

> Parlous. Inadequate. Unsustainable. Just three words that could be used to describe the current state of funding for adult social care. We don't think anyone would argue that current funding levels are high enough to deliver a system that works for those in need.

Increasing costs of adult social care is one of the major issues facing local authorities in England. Social care expenditure currently represents 38 pence in every pound spent by councils (up from 34 pence in 2010/11).

According to the Association of the Directors of Adult Social Services (ADASS) Budget Survey 2018, the primary strategies used to reduce local authority spend in recent years were efficiency saving (more for less) and service reduction. But these are now "no longer a viable option for making savings, partly because scope to do this has now been exhausted and partly because the external constraints, such as National Living Wage and the fragility of the care market, limit councils' ability to do so".

Funding by region



Despite rising needs, the number of adults receiving publicly funded care has dropped by around 400,000 between 2009/10 and 2016/17 demonstrating how local authorities are reducing the support they offer. With care and support only being provided to those with the highest need, it is estimated that 1.2 million older people have unmet care needs (source: ADASS Budget Survey 2018).

A further challenge is that local funding sources do not naturally tie up with where older adults in need of care choose to live. For instance, 55% of England's over 65s reside in county areas. This number is set to rise at 2% each year by 2020. However, counties receive nearly £450 per elderly resident less than inner London.

Local authority funding of social care has dropped in real terms by 11% per adult in England according to the Institute of Fiscal Studies (IFS), and showed a clear geographic pattern.

Alongside the drop, funding has become shorter term with a number of temporary sticking plasters. The Better Care Fund has targeted integration, although some would argue has been too focussed on reducing NHS costs. The LA precept allows authorities to increase council tax by 3% per year, but suffers from the fact that councils in greatest need of funding are often least able to raise council tax further.

Underlying all of this is the fact that over two thirds of care is delivered 'informally', mostly by family but also by friends. It demonstrates how key that part of our social fabric is financially, as well as from a broader perspective. The demographic bulge of the baby boomers aging will add further pressure, but even today those without children face a tougher future.

The role of private insurance in paying for care

Attempts in the past to create care insurance products have not proved very successful. Those that help pay for care costs have often resulted in higher than expected claim costs and subsequently high prices. This has suggested that the market could benefit from the creation of insurance products that do not fully indemnify customers. For example, they could pay out a fixed amount of cover, or be designed to work in unison with state benefits and provide protection up to some upper limit or cap. Beyond the cap the state would pick up the bill, as proposed by Dilnot.

Since Dilnot, the insurance industry has responded by creating new protection insurance products that give customers the ability to draw down on their conventional life insurance policies in the event they meet defined care criteria. However without a government cap on care costs, such products cannot provide complete indemnity or provide peace of mind for customers.

Product	What is it?	Pros	Cons
'Immediate needs' annuities	Buy on entering care. Pay upfront lump sum to guarantee income to pay for care until death	Majority of care costs covered until death	Expensive. The average premium is around £100k. For policies without a guarantee period there is no return of capital in the event of an early death, and so perceived poor value for money. Erodes value of estate
'Deferred immediate needs' annuities	Buy before entering care. Income delayed for e.g. 1 year, then guaranteed income to pay for care until death	Cheaper than 'immediate needs' annuities	For policies without a guarantees, there is a risk of not surviving the deferment period, and therefore not receiving payments
'Whole of life' policy with a long-term care acceleration	Pays a lump sum when you die, with acceleration of the lump sum payment if and when long-term care is needed	Seen as a good halfway house for workers and insurers	Lump sum will not cover all care costs Claim triggers may not be aligned with care requirements
Conversion features in critical illness protection policies	At end of term of critical illness policy, some of the original sum assured can be converted into a new policy that pays out if customer suffers from one of a list of degenerative diseases	No need for consumers to take action as cover kicks in immediately following the end of term of the critical illness policy, and will effectively continue as a whole of life benefit	Lump sum will not cover all care costs Claim triggers may not be aligned with care requirements

One area of growth for the insurance market has been the development of Equity Release mortgages, and more recently Retirement Interest Only mortgages. These provide a way for people to access their housing wealth to help fund their own retirement and care needs. However, such products can only be part of the solution due to:

1. **Growing regulatory headwinds to the valuation of these products.**
2. **Concerns over mis-selling.**
3. **A general desire for people to pass on as much wealth to future generations as possible.**

It's clear that whatever role insurance plays, it needs to seamlessly dovetail with state funding, and there needs to be a clear incentive for customers to save for and insure their own care needs.

A better future for funding

A better model for funding has to include contributions from both individuals and the State to be acceptably affordable to all. We are not aware of anyone who argues that current funding levels are adequate in the system.

How big is the funding gap?

According to the King's Fund, relative to the projected level of available funding for England:

- To revert to 2009/10 levels of funding would cost an additional £6bn pa by 2021 and £15bn by 2031.
- To introduce a cap on fees of £75,000 and a protection for people's assets with a floor of £100,000, would cost an additional £4bn of funding every year by 2021 and £6bn pa by 2031.

The cap is an essential part of building the case for a functional insurance market. This would also limit catastrophic care costs that the unlucky few suffer. This is often proposed hand in hand with protection for people's assets for up to £100,000, to allow them to protect some assets for example to pass on as an inheritance. If the Government provides a cap, the private sector is much more likely to be able to help people to save for costs up to the cap.

- To offer free personal care in England as is offered in Scotland would be a further £6bn pa by 2021 and £8bn pa by 2031.

So in total, to fund a sustainable system, while protecting individuals against catastrophic costs would, by 2031, would cost nearly £30bn above the projected level of available funding.

This additional spending is nearly one quarter of the entire NHS budget for 2017/18, or the size of the entire budget for secondary education. This demonstrates the yawning gulf between where we are and where we might modestly aspire to be.

How can we plug the gap?

Independent Age recently considered nine different tax raising options. They ruled out five as generating too little to make any meaningful difference. The four that remain are:

Option	Revenue generated in 2030/31 (current prices)
Increase all rates of income tax by 1p in the £	£6.5bn
Increase all National Insurance rates 1%	£10.5bn
Introduce an age related levy from age 40 to state pension age of 0.7% (similar to Japan)	£5.7bn
Introduce a lump sum payment of £30,000 payable by people with net household wealth above £100,000 at state pension age	£13.7bn

There are clearly other options available too. For instance, private sector pensions are typically saved tax free as they are seen to be 'deferred pay' which is taxed at the point of payment. However, actual pay is subject to National Insurance whereas this form of deferred pay is not. A National Insurance tax paid by pensioners would also be a route to passing some of the tax burden of improved social care to the retired generations as well as to the working ones.

Government figures[3] suggest that 10 million people of working age are saving, or saving more, into a pension due to auto-enrolment. This is part funded by employees, part by employers and, part by tax relief. The Government has hinted that this might be one route to support greater saving by individuals towards the cost of their own care. The Government estimated that these 10 million people would be saving an additional £17bn per annum.

However, asking this same cohort to save for themselves, while also paying the taxes for the current generation's social care does not seem equitable. It would also require current pension auto-enrolment contributions of 8% of band earnings to rise substantially. Many people already need to increase contributions substantially to give themselves a chance of saving an adequate retirement income.

In addition, asking those of working age to save more into a 'pension and care' pot runs contrary to the recent trend in Government taxation policy of limiting tax relief for current workers saving towards their own retirement. However, any financially sustainable solution for adult social care will have to break several moulds.

To be acceptable, we have argued there needs to be engagement and education with the public about the current state of social care and so how the additional funding could help.

How do we better integrate commissioning across health and social care?

To drive funding into the right areas, we need jointly integrated commissioning of services across health and social care. These should be given a degree of local freedom to target specific needs which do vary across the country, and between urban and rural areas.
Two countries often cited for their effective approaches in this area are Japan and Germany. The table below sets out the key elements of their system:

The UK government is considering following the German model, with a levy of 2.5% on wages targeted at the over 40s. Employees and employers would split contributions. These funds would then be ring-fenced for social care. It remains to be seen if there can be cross party consensus and the political will to push this through.

	Japan	Germany
Funding	c50:50 split between direct state 'insurance premium' and general taxation	Direct state 'insurance premium'
Protection	Those over 65 and some over 40 with disabilities	Those who have contributed for more than two years, subject to a needs test
Cover	Most needs covered by health or care insurance	Most home based needs, plus 50% of institutional care costs. People advised to supplement with private insurance as an additional layer on top of state insurance.
Provision of care	Almost entirely private sector, with a mix of for - and not-for profit.	

It is worth emphasising that collectively we will pay for the care we receive. Whether it is via direct hypothecated taxes, indirect taxes, insurance, direct payment from assets, or deferred payment for those with houses – we need to pay somehow. What the state can be expected to do is to help:

1. Ensure funding levels are adequate and sustainable.
2. Try to put together a funding model which is 'fair'. This includes helping to spread the risk of catastrophic costs to prevent care costs leading to financial ruin, and also ensuring the burden is spread fairly across generations.
3. Use the funding well, for instance investing in prevention to save money in the long run and improve people's lives.

In our view, the Government policy is failing badly on all three of the above measures.

[3] https://www.gov.uk/government/news/the-number-of-people-saving-as-a-result-of-automatic-enrolment-to-hit-10-million

Preventative measures

> Prevention is better than cure, and early intervention is better than crisis management. To deliver on the promise of this we need a system that has the funding stability and time horizon to deal with more than today's crisis. The opportunities abound. Not only do the following approaches reduce total costs for society, they also greatly improve the outcomes and experience for individuals:

Primary and community health and social care are far cheaper than hospital treatment where it can be avoided. But to deliver it requires enough trained GPs, community and district nurses and social workers.

Support with wider health and wellbeing is part and parcel of Local Authorities' remit, but again they need the resources to deliver. Improvements in diet, smoking, alcohol consumption and exercise can have dramatic impacts on individuals' health and so reduce health and care needs in the long run.

The built environment affects many aspects of older adults' health and wellbeing, from the risk of falls, to the relative ease of staying in their homes through adaptations, to the ease of socialising locally and feelings of loneliness. The cost of ensuring all new homes are accessible and adaptable to enable people to live as independently as possible for as long as possible has been estimated by the Government to only cost £521 per home, but over time substantially raise the proportion of our housing stock that was suitable to all.

Technology is rapidly transforming all aspects of our life, and health and social care are not immune. From the latest telecare systems, to wearables and smart home devices, technology can reduce the cost of care, improve the quality of care in the home, support carers in their roles alleviating stress, and help the coordination of all care givers with a people centred focus.

The view from the Centre for Ageing Better - Adult social care:
Prevention starts at home

Living in a suitable home is crucially important to a good later life. It can improve people's physical and mental wellbeing, enable them to stay socially connected, and to carry out day-to-day activities safely and comfortably.

But current UK housing stock is not fit for our ageing population. More than 90% of older people in England live in mainstream housing, as opposed to specialist housing or residential care, and 80% of the homes we need by 2050 have already been built. These are some of the oldest houses in Europe and are mostly not accessible or adapted to meet people's needs as they get older, with 93% lacking even basic features of accessibility.

While many people will maintain good health and fitness in their later years, the likelihood of having one or more long-term conditions, physical impairments, disabilities and frailty increases with age. By people's late 80s, more than one in three people have difficulty undertaking five or more activities of daily living unaided. This means difficulties with things like washing, going to the toilet, and eating which in turn brings huge pressure on health and social care services – pressure that will only increase in the coming years as more of us live for longer.

Ultimately, we need to start future-proofing the homes we build so that all new housing meets basic accessibility standards and meets our changing needs across the life course.

But in the meantime, home adaptations, such as grab rails and level access showers, are a highly effective way of adapting our existing housing stock and improving the accessibility and usability of a person's home environment.

An international review we commissioned highlighted their life-changing impact, particularly when combined with necessary repairs and home improvements, delivered in a timely manner, and in line with people's personal goals.

Our report, 'Homes that help', found that some people delay making changes to their homes because of the clinical appearance of adaptations and their association with vulnerability; are often unaware of how to access home adaptations; and for some the process can be so complex that even professionals struggle to navigate it.

The fact is that for a relatively low expenditure, the potential gains of home adaptations are significant for individuals and society, and yet their profile and priority is limited. While there has been an increase in national funding for home adaptation through Disabled Facilities Grant (DFG), local provision is highly variable and there are still few local areas taking a prevention-focused approach to providing adaptations to older people's homes.

Furthermore, despite the obvious interdependencies between health, housing and social care, and the wide-ranging impacts of home adaptations, particularly for reducing pressure on NHS, these connections are not yet being fully recognised or reflected in wider policy, funding systems or NHS practice.

We need a joined-up approach and shared objectives across these areas that are embedded within planning policy frameworks, Sustainability and Transformation Partnerships, Joint Strategic Needs Assessments, Better Care Fund plans and NHS local plans.

Rachael Dorking
Senior research manager
Centre for ageing better

The shape of our future society

Club Vita is a centre of excellence for improving the understanding of human longevity. Using its market leading data set combined with data from the Office of National Statistics it has examined some key areas of our societal make up related to the developing need for social care:

Living a long time in retirement is likely

A typical female pensioner retiring today has a 51% chance of living to 90 years old. By 2030, this will increase to 58%.[4]

The chance of surviving to 90 is only slightly lower for men. A typical male pensioner retiring today has a 38% chance of living to 90 years old. By 2030, this will have increased to 45%.[4]

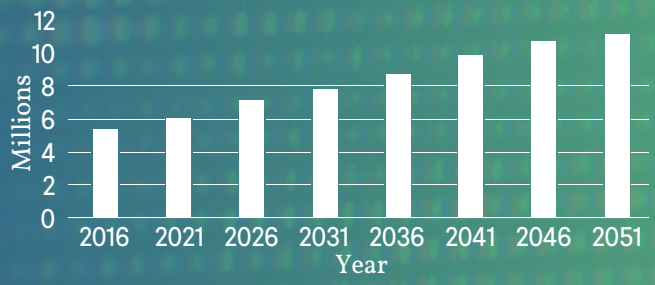
This chance of living a long time is not equal across society

Socio-economic factors such as wealth, lifestyle and health can have a significant effect on how long people are expected to live. A man retiring today could have as low as 20% chance or as high as 54% chance of reaching 90 depending on their socio-economic background. (For women this range is between a 27% chance and a 57% chance). [5]

There will be a lot more older people

Increasing life expectancies and the current demographic profile of the UK will result in a lot more people in older age in the coming years. We don't currently have the infrastructure to cope, nor is there any credible plan to build it at present.

Number of people in the UK over 75 years old



Source: ONS 2016-based National Population Projections

CLUB VITA brings together a community of organisations, including over 220 of the largest pension schemes in the UK, to pool experience data on how long people live. The unique data set, which now covers over 2.9m lives (over 1 in 4 pensioners in the UK that have a defined benefit pension) and 1.5m deaths, allows Club Vita to provide unique analytics and insights to help a wide range of stakeholders manage their longevity risk more effectively.

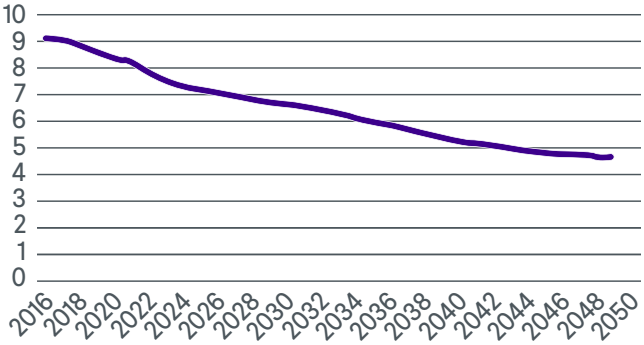
[4] Based on someone retiring at age 65 using a typical Club Vita "CV18" base table curve increased in line with CMI_2017_[1.75%] improvements

[5] Based on Club Vita analysis for the most and least long lived groups of pensioners in the Club Vita "VitaCurves" model

The ratio of younger people to older people is changing

- The number of younger people supporting the older population is projected to reduce dramatically.
- The chart shows how the number of 15 -75 year olds for every over 75 year old is projected to change in the future. It reduces from around 9 to under 5 by 2050.

Number of 15-75 year olds for every over 75 year old



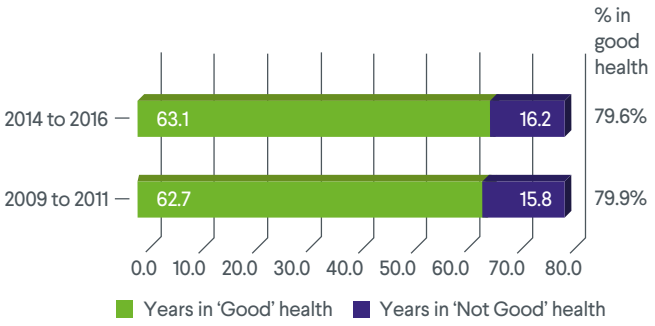
Source: ONS 2016-based National Population Projections

How long will people stay healthy?

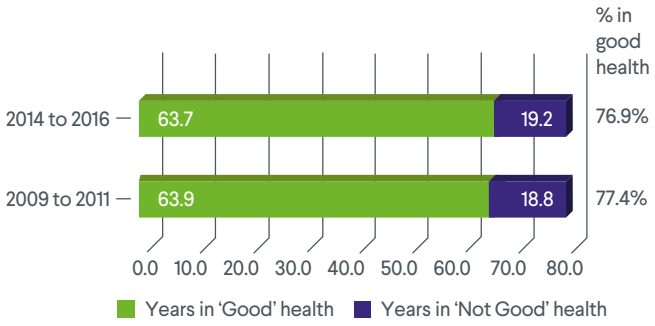
Whether a longer life is seen as a positive will be influenced by how long people are able to live healthy lives.

- Female period life expectancy[6] has increased between 2011 and 2016, however the expected time living in 'good health' (as defined by the ONS) has actually decreased slightly.
- For both men and women the proportion of life expected to be in good health has decreased between 2011 and 2016.

Male health state life expectancy at birth in the UK



Female health state life expectancy at birth in the UK



Source: ONS, Health state life expectancies, UK: 2014 to 2016

> "Taking these demographic insights together, we can see there will be more older people, needing more care for longer, with fewer younger people to support them. The system is already past breaking point, yet it needs shoring up and its capacity improved to support us all as we age."
>
> - Erik Pickett, Longevity Consultant, Club Vita

[6] Period life expectancy does not take into account any potential changes to mortality rates in future.

The View from Royal London:
Re-branding financial provision for care as 'inheritance insurance'

One of the big challenges in addressing the issue of long-term care funding is that very few of us are willing to contemplate a time when we are no longer able to look after ourselves. As a result, few people are willing either to save for (highly uncertain) future care costs or to seek out insurance options. But there could be a way round this problem if we frame the issue differently.

If you face 'catastrophic' care costs in later life, perhaps because of a prolonged stay in a residential care home, paying these bills is likely to eat into the value of any property that you own. Outside Scotland, where different rules apply, public funding currently only cuts in when an individual has largely exhausted their private wealth beyond a modest disregarded amount. As a result, many thousands of people each year have to 'sell their home to pay for care'.

Given that people are motivated by the desire to pass on the value of the family home to their children, one way of focusing minds on potential care costs is therefore to suggest that financial provision for care is a kind of 'inheritance insurance'. Under such a model, those who had insurance to cover care costs would not be at risk of having to fund care by running down the value of their housing equity.

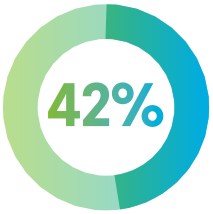
One way to design such a product would be to combine this sort of insurance with existing pension drawdown products. Growing numbers of people will in future reach retirement not with a final salary pension but with a defined contribution pot. As these pots grow in size, bolstered by transfers out of defined benefit arrangements, more and more people could countenance paying a lump sum premium at retirement so that any future care costs would be met by their insurer rather than funded out of the value of their home. Such a policy would be more attractive if government agreed that premiums into this form of insurance could be paid directly from the drawdown account to the insurance provider without the deduction of tax.

The rich can self-insure against future care costs and the poor will end up relying on the state. But a large group in the middle might welcome a new financial product which would ensure that their care costs were met and the family home was protected for the benefit of future generations.

Steve Webb is Director of Policy at Royal London. A fuller discussion of these ideas is in 'Is it time for the care pension', which can be downloaded from www.royallondon.com/policy-papers

Steve Webb
Director of Policy
at Royal London

Public attitudes to care



of UK adults don't ever expect to save for care

Care without nursing costs **£30k pa on average.**

Almost half of UK adults think it costs less than this.

of baby boomers expect to ever be in a residential care home.

expect to be in one with nursing.

Yet **1 in 10** reaching **age 65** face care costs of over **£100k**

37% don't think housing wealth should be used to pay for care, rising to almost half of baby boomers

Having canvassed the views of 2000 people across generations it's clear that there needs to be engagement and education with the public about the current state of social care and the need for change.

At the moment:

People aren't providing for their own care
While there is an almost universal acceptance that it's important to insure yourself against unexpected costs and to save for unexpected events, 42% of UK adults don't ever expect to save towards their care.

There is widespread opposition to using personal wealth to pay for care

Less than 1 in 3 think that housing or other forms of personal wealth should be used to pay for care.

There is little support for younger generations funding the care of older generations

Across all generations the majority don't believe their care should be paid for by younger generations. Only 15% of baby boomers and 19% of generation X hold the view that younger generations should fund their care. Millennials are the outliers here, with 40% believing the next generation should fund the care of the previous.

On a more personal level the results are very similar. Only 8% of baby boomers, 17% of generation X and 41% of millennials think children should fund the care of parents.

Very few believe they will need residential care at some point in their lives

The lack of support for most forms of funding could lead to the one of two conclusions: either the public assumes the money is already there or do not appreciate the risks of them needing care. Our research supports the latter. Only 5% of baby boomers ever expect to be in a residential care home, and only 2% expect to be in one with nursing at some point in their lives. The numbers are very similar for the next generation: only 6% of generation X expect to be cared for in a residential home. Again millennials have a very different view to that of the older generations, with 45% expecting to need this level of care.

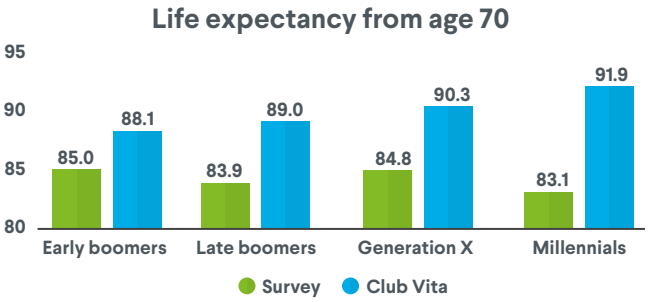
Footnote: Over 3000 people surveyed across the UK by Opinium late 2017.

Almost half the population under-estimate the cost of care

Many also underestimate the cost of care 47% believe residential care without nursing costs less than it does, which is around £30k per annum on average.

Most people underestimate how long they'll live for

Clearly demographics play a key role in the likelihood of needing care. The chart below shows how long people expect to live for against their likely life expectancy from age 70. All generations underestimate how long they're likely to live, so it comes as little surprise that expectations of needing care are low. The younger generations are vastly underestimating their probable lifespans, but interestingly they take a more pessimistic view of their likelihood of needing care than older generations.



The early boomers, who are already in their late 60s and 70s, have a much better feel of their chances of reaching age 80 than younger generations. However all groups, including the early boomers, significantly underestimate their likelihood of reaching 90, with younger generations undershooting by more.

Surprisingly, in each group there are around 10% of individuals who think they will make it to 100, which is broadly correct. The main shortfall is in the age range 90 to 100.

A huge political challenge

All of the above illustrates why addressing the crisis in adult social care is such a difficult political challenge. In the context of these findings, it's not entirely surprising that successive governments have ducked the issue.

The Conservative Party's "Dementia Tax"

In 2017 the Tories had their fingers burnt trying to find new ways to pay for care. The election campaign of that year was nearly derailed by the so-called "dementia tax", forcing the prime minister into a U-turn only days after announcing the policy.

Currently anyone with savings and other assets worth more than £23,250 is expected to pay the full cost of their residential care and the value of their home can be taken into account. But this does not apply to those receiving care in their own home.

Under the Conservative plans, it would have applied to those receiving care at home and the value of property would have been factored in. However the money would not be taken from an estate until after an individual's death, and £100,000 from that estate would be protected.

One of the main reasons for the U-turn was the fear of upsetting the 'grey vote'. From our research it's clear why the Tories were nervous. Almost half of baby boomers don't think housing wealth should be used to pay for care and only 1 in 5 do. 47% of this generation also feel it's important to leave a financial inheritance for their children.

While the Tory plans would have protected £100,000 of an individual's estate (in the context of an average UK inheritance of £147,000), thousands of people would have paid more for home care and potentially leaving a smaller estate to pass on to their families. Some criticised the policy as complex and a challenge for councils to implement. Others pointed to the risk of unintended consequences, particularly discouraging people from seeking help, placing a greater burden on unpaid carers and driving increased use of hospitals and long-term care.

Putting the rights and wrongs of the policy to one side, it does illustrate how difficult it is to implement change.

A call to action

> It's time to treat older adults with the dignity and respect they deserve. There are many families, carers and individuals who are completely unaware of the state of social care in this country and shocked when they find out the reality. As awareness grows, we believe the pressure to improve the system for everyone can only increase. We would be delighted if this paper can play a small part in growing that awareness.

Implementing change in a system of this scale and complexity will involve devilish detail. However, at a high level many of the remedies are obvious. What we call for is:

- A statutory office for health and social care that can provide independent oversight of the sector and of our politicians, to give credibility and confidence in the changes being made.
- More money coming into the system on a sustainable and long term basis funded by a partnership between individual and state.
- That money being much better spent, on people centred care that improves outcomes for individuals in need in a way that costs us all less in the long run.
- Improvements to the way the system treats individuals, in the joins between health and social care, and through integrated commissioning of this care. Individuals shouldn't have to worry about who is taking responsibility for them in their hour of need, the system should be designed to do that for them.

Cross party and wider leadership will be required to explain the current situation to people and so build the case for change. Bravery will be needed. It won't be easy, but to build a better future for our society, it is an effort well worth making.

About Hymans

Established in 1921, Hymans Robertson is one of the UK's longest established independent firms of consultants and actuaries. We deliver a full range of services including investment, actuarial and benefit consulting, risk modelling and consulting, project management and third party administration.

Our firm was set up with the principal aim of providing actuarial services to public sector pension schemes. Our dedicated public sector team is the largest and most experienced in the marketplace, providing investment, actuarial and benefits consultancy to almost half of the funds in the scheme.

At the forefront of our industry, we're influencing the way it works. We engage with the debate on LGPS structural reform and devote significant resource and investment to LGPS governance. We provide input to draft regulations and policy decisions through formal consultation, and actively engage in discussions around the ongoing challenges relating to public sector pension provision.

We pride ourselves on finding the answers that deliver the right outcomes through fresh, innovative ideas. We believe everyone has a right to a better financial future – we help our clients ensure it's not left to chance.

HYMANS ROBERTSON
CLUB VITA

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