

A funding settlement that works for people, not services

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Introduction

We are at a critical point in the history of social care reform. A process which arguably began with the JRF Inquiry into the Costs of Continuing Care in 1996, followed by a succession of commissions and consultations, seems finally to be drawing to a close. It has been a tortuous journey, spanning four separate administrations and as it turns out, all three major political parties. But 2011 may just be the year that a new settlement for social care funding is agreed upon.

At the time of writing (August 2010), we await the Comprehensive Spending Review which will set the pace of care funding for the next four years, and an articulation of the Coalition Government's vision for adult social care. The Commission on Funding of Care and Support is due to make its recommendations in December 2010. In April 2011, the Law Commission will propose its recommendations on a new social care statute. Together, it is hoped, these will form the foundations of a permanent settlement for how we all contribute towards our care in later life and the system that delivers it. The big question is: will the proposed funding settlement and statute be aligned with each other and – critically – with a vision for social care that is designed around people's lives, rather than around services?

Several alternative models have been developed over the last 15 years, some drawing on systems used in other countries which can have important lessons for the UK (Glendinning and Bell, 2008). The JRF, ILC¹, Kings Fund² and Policy Exchange³ all provide useful overviews, outlining the pros and cons of variations of co-payment, social insurance and hybrid models. But in weighing up the minutiae of how each system functions, we have all risked losing sight of the end goal. People.

Only a funding system acceptable in principle and in practice to those who contribute to it will survive over time. The NHS owes its longevity to this fact. Only a funding system which is aligned with the whole of people's lives, as well as their relationships with families and communities, will succeed in delivering care and support fit for the 21st century.

The principles

Everyone agrees that there are three key principles for a future funding settlement (Hirsch 2006, Collins 2009). It has to be:

1. fair;
2. transparent – simple to understand; and
3. sustainable.

This provides a good basis on which to compare the range of current models, but it is not the whole picture.

Fairness is open to interpretation (Bell and Keen 2009) and will look very different depending on one's ideological perspective or values (Keen 2008). *Sustainable* is often taken to mean financially sustainable – that is, capable of raising adequate funds to cover care costs both in the immediate and longer term. Less consideration is given to whether care funding is *socially* sustainable: will

¹ Lloyd, J: *Building Blocks*, ILC UK2008

² Humphries R, *Securing Good Care for More People*, King's Fund 2010

³ Featherstone, H: *Careless* 2010

today's care funding settlement be appropriate as society's expectations of social care, community support and informal care change? Will it be flexible enough to cater to the needs and preferences of an increasingly diverse population?

In posing these questions, it becomes clear that we cannot isolate the 'how' of care funding from the 'what' is being funded. In order to be truly deemed fair; to be understandable by resonating with the reality of our lives; and to be financially *and* socially sustainable, a future care funding settlement must be able to fund and facilitate – even to incentivise – the *type* of support people want. To do this effectively, the settlement must start with an understanding of how people live their lives. This is very different from a focus on services or settings (e.g. own home, care home).

Consultation with service users as part of JRF's *Shaping our Lives* project found that people express their needs and aspirations, and live their lives, in terms of self-defined outcomes rather than services. People view outcomes from a holistic perspective, thinking about housing, transport, employment, income and benefits, and broader issues around discrimination and equality without separating these into neat service areas (Turner et al 2003; Glynn et al 2008). More recently, older people living in residential care homes identified their outcomes for 'a good life' in a residential care home (Bowers et al 2009). JRF has further work underway to identify and validate what older people with the highest support needs want and value from life. Service-based assessments and delivery seldom make sense to people. Service-led distinctions between (for example) social care and health do not resonate with how people live their lives, and cause confusion for users and practitioners (Beresford 2010).

So, in order to create a funding settlement which is compatible with how people live their lives, and what they want and value from life, we must add a fourth principle:

4. capable of supporting self-defined outcomes.

Why is an outcomes-based funding system so important?

Perhaps in response to the substantial body of research which forcefully demonstrates the irrelevance of service silos to people's life, independence and sense of wellbeing, the current care system is increasingly interested in outcomes. The ASCOT tool developed by PSSRU is the latest example. Outcomes-based commissioning is becoming more common (in policy, if not in practice). Outcomes-based assessments are now a central pillar of personal budgets. The Law Commission's proposed new Social Care Statute is set to create a system based on needs and outcomes rather than service entitlements. The last thing we need is a funding settlement which maintains or reiterates old service-based assumptions about social care.

A system which begins with an understanding of people's lives, and resonates with their lived experiences, is likely to be publicly acceptable, and therefore sustainable, over the longer term. We should also keep front of mind that we are an increasingly diverse nation – in terms of our different needs, life experiences, lifestyles and expectations – shaped also by ethnicity, nationality, gender, sexual orientation, belief, social class and age. A system which is overly prescriptive regarding service entitlements will soon become restrictive and will date very quickly as society moves on in its understanding of care and support, old age, entitlements and responsibilities (whether individual, family, community or state). In contrast, a system which starts with a focus on facilitating outcomes, can be adaptable enough to survive even when technological breakthroughs or wider social, economic or political transformations have re-invented what we think of as social care.

What would a settlement enshrining all four principles look like?

If we consider each of the four principles in turn, it may be possible to establish which elements of existing funding models are most promising.

What is fair?

Fairness is a problematic and subjective term (Keen 2008). At the very least, all funding models must have a minimum entitlement – a safety net – for the poorest in society, and the amount people contribute must be related to their ability to pay. Funding care from general taxation is popular with some for its simplicity, parity with the NHS, and its progressive element – i.e. people pay according to their income (Beresford 2010). However, there are other forms of fairness which need to be taken into account – as well as the contested issue of how sustainable the current funding system for the NHS really is, and whether there is a case for increasing the levels of top-ups and co-payments that already operate within the health system (Featherstone 2010, Reform 2010).

Intergenerational fairness is very important in care funding, given that the system will need to work for successive cohorts. This includes cohorts of comparatively affluent and asset-rich (even if income-poor) older people, as well as those of working age who have incomes, but may not have the opportunity to build up assets like previous generations. A care levy, paid for through a combination of National Insurance and inheritance tax, with the latter reducing for successive cohorts of older people, is a very interesting and potentially effective way of catering to the different financial situations of different generations. As this is also based on NI contributions, it also achieves within-generation redistributive fairness (Hirsh and Spiers 2010; Burke 2010 in this journal).

Given that care has an inequitable impact on men and women, as women tend to provide the majority of informal (and formal) care and are more likely to need care themselves due to longevity, we also need to consider gender fairness (Himmelwait and Land 2008). A funding settlement which takes into account informal care as a form of contribution, in lieu of financial contributions to a funding/insurance pot, would ensure those who leave the labour market to care for relatives can continue to build up their own care funding contributions. A funding settlement which takes into account the additional costs of financial and respite care for informal carers when calculating people's contributions would also be a step in the right direction.

A fair settlement will also have to take into account the fact that older people of tomorrow will reflect the increasingly diverse younger population of today. This requires a funding settlement that is flexible enough to enable all older people to achieve their desired outcomes and not exclude or penalise any one group. This raises questions about the entitlements, for example, of disabled people with support packages already in place who turn 65 years old. Recent JRF-funded research into the over 50s living with HIV is another prime example of how our changing society will directly affect the population of older people in years to come (Power et al 2010).

What is sustainable?

A financially sustainable funding settlement must generate revenue in the immediate term, to support the provision of care for current older people, as well as generate sufficient resources over the longer term for future cohorts. A two-stage funding system, combining immediate payments plus gradual contributions, could achieve this (Hirsch and Spiers 2010), as might insurance models which transfer risk to the private sector rather than individuals or the state.⁴

⁴ Lloyd, J: *Building Blocks*, ILC UK2008

We must also consider sustainability in a wider sense. A settlement which can effectively generate resources, but which is unacceptable to those contributing, will not be sustainable. This is the concept of social sustainability, closely associated to fairness, in that a settlement which is generally seen as fair is more likely to be socially sustainable over time.

Social sustainability also requires recognition that individuals are part of families and wider communities. They can provide support to, and be supported by, the wider community. A socially sustainable funding settlement will have to reconsider the wider networks and dynamics involved in providing and receiving support through family, friends and community (Gandhi and Bowers, 2008) and facilitate individual and community responsibility, *but at the same time*, not pre-suppose an endless supply of 'free' informal care (Brindle 2008).

These elements come together in relation to the provision of low-level support ('that bit of help' as the JRF Older People's Inquiry termed it). We know people value preventative services (Raynes et al 2006). We think that any funding settlement that narrowly targets only older people with the highest needs is a recipe for escalating costs – as is any society that fails to enable mutuality, reciprocity and self help.

What is transparent?

The current system of social care eligibility and its funding is opaque and confusing for those who need care and support (Hirsch and Spiers 2010). To be transparent and easy to understand, a new funding settlement will need to state clearly how much people are expected to contribute, and what they will get in return. The minimum entitlement, or safety net for the poorest, will need to be explicit.

One easy to understand option is the tax-funded universal care model (Beresford 2010). However as Policy Exchange argue, this would cost £106bn per year and would be akin to supporting a second NHS.⁵ Hirsch and Spiers suggest ring-fencing portions of existing revenue streams as an alternative but equally transparent approach. Both approaches are compulsory forms of contribution. Voluntary insurance systems could also work if combined with excellent and effective awareness raising, information and advice so that people understand the vital importance of contributing to care costs, and are clear about what they can expect in return for contributing. This would allow people to make the sometimes rational choice *not* to contribute to their care, if they have very low incomes and are likely to be eligible for state-funded care in later life, and could help improve the overall awareness and image of what social care is, alongside other issues such as tackling ageism, supporting active ageing, benefits and rights. Information – accompanied by advice and advocacy – are in short supply and highly valued by older people and their families.

Transparency is also about eligibility criteria and needs assessments. The public is entitled to clarity on how, when and why they would be able – or unable – to access the support to which they have contributed. This is something that any and all funding models need to address (irrespective of whether they are outcomes-based or service-based).

What is an outcomes-based funding settlement?

Whilst linking a funding settlement to *outcomes* is relatively unexplored territory, the good news is that none of the main funding models proposed actually *preclude* an outcomes approach.

An outcomes-based settlement will need to define a set of outcomes which the public can expect as a minimum entitlement – either from the Government as a safety net, or in return for a minimum

⁵ Featherstone, H: *Careless* 2010

contribution. Any funding model currently configured around a minimum entitlement to *services* could be adapted to allow for a minimum entitlement to *outcomes*.

- Co-payment models and outcomes

We must bear in mind that the setting of outcomes is a subjective and personal process, which must have individuals at its heart (Turner, 2003; Glynn et al 2008; Bowers et al 2009). Therefore, a minimum entitlement to outcomes needs to be complemented by a system which enables individuals to define their own outcomes and use their care funding to achieve those outcomes. Co-payment models are very conducive to this, as the minimum entitlement to outcomes could be designated as 'state funded', whilst the additional contribution made by individuals could be reserved to achieve additional self-defined outcomes. This would of course mean that the very poorest older people might have limited opportunity to set their own outcomes, reliant as they would be on the state-funded minimum entitlement. The design of that minimum entitlement would therefore be crucial, and should build on the extensive knowledge we already have about what people who use and give care want and value. The very nature of an outcomes-based approach should mean that all individuals have greater opportunity to influence *how* those outcomes are met, thereby delivering greater choice and autonomy than would be the case with a minimum entitlement to a prescribed type of *service* or a prescribed type of setting.

- Insurance-based models

To raise the individual funds necessary to secure self-defined outcomes, some form of insurance-based model would also work. Self-defined outcomes, and how they might be achieved, would, by definition, be extremely variable. The range of costs is likely to be large. Therefore, a model which pooled the risks of some people requiring very costly support would offer a financially sustainable approach. The drawback of current insurance models is that they pay out on, and so the premiums are calculated on, the risk of needing services (e.g. residential care) and the cost of those services. Adapting this to calculate the risk and costs of outcomes may not be viable. We are not aware that anyone has attempted to do this yet (which isn't to say that it shouldn't be tried).

Calculating the risk and cost of need as a proxy for outcome costs could be one solution. Both voluntary and compulsory insurance models are viable in this context, and could be combined with a care levy system (Hirsch and Spiers 2010) to pay for the premiums in a way that is progressive and fair across generations.

The challenges of an outcomes-based model

1) Defining a minimum entitlement

We know that people do not identify outcomes in single service areas, but rather talk about their lives in relation to health, care, housing, transport, employment, income and benefits (Turner 2003) as well as maintaining and developing friendships and social relationships, a meaningful community life, and personal identity and self esteem (Godfrey et al 2004, Raynes et al 2006, Bowers et al 2009).

A minimum entitlement which (if a co-payment model were used) would be paid for by the state, would need to include (or at least recognise) all of these various aspects of a person's life. Social care outcomes cannot be defined in isolation from the rest of people's lives. Nor can they be defined, designed in, or delivered against without co-production involving users, carers and frontline practitioners – and with the active support and buy-in of commissioners and suppliers (Mauger

2010). As such, ASCOT⁶, a valuable but nonetheless narrowly-defined set of care-related outcomes, could be used as a basis that would need to be supplemented with other wider outcomes.

Unfortunately, the current focus on the integration across health and social care doesn't appear to have extended to other areas such as housing, even though we know housing is critical in enabling people to enjoy later life (HAPPI 2010).

2) *Calculating the cost to the state*

The costs to the individual - or the state in a co-payment model - of funding a minimum entitlement will need to be determined. This has proved to be a challenge for existing models, and many are still not wholly certain how much the overall costs or contribution levels will be (particularly if the settlement includes a voluntary insurance element, as premiums will depend on the number of people who decide to contribute). Calculating the costs to the individual and the state could be even more difficult for an outcomes-based model, in that we do not have readily available unit costs for the achievement of outcomes, and in any case this will vary from person to person.

If we assume the state will pay for some portion of care in a co-payment model, it may be the case – particularly in the current economic climate – that the state may have to consider how much it is willing and able to contribute to people's care, and set outcomes within those financial parameters. These parameters would need to take into account the diversity of people's care needs, which would directly affect how much support people required to meet the minimum outcomes. It is likely that the Government would provide very different amounts of funding to different people, to achieve the same outcomes. That said, the Government will still have to ensure that the funding provided can deliver a minimum set of outcomes that is generous enough to be meaningful to people and act as an acceptable safety net for the poorest older people with the highest needs. That minimum entitlement would ideally include scope to support a degree of lower-level as well as high-level support. A variant of the methodology developed to define a 'minimum income standard' (Hirsch et al, 2010), the Sarkozy Commission's attempts to cost societal wellbeing⁷ and others, could help provide a benchmark as to how much the Government *should* be prepared to pay to ensure the minimum entitlement is set at an acceptable level.

3) *Calculating individual contributions*

The same applies to the setting of people's contribution levels. Aspiring to meet every self-defined outcome (even from a risk-pooled insurance system) could become financially unsustainable. Premiums would rise dramatically if, for example, a person were to set particularly aspirational outcomes or choose to meet those outcomes in a highly costly way. To overcome this, the funding settlement would have to start with a set amount of funding which people could spend in any way they felt was appropriate to meet their own outcomes. This is similar to personal budgets, where the amount given to an individual to spend is determined by need (though locally variable) and is spent on the attainment of self-defined outcomes. If an outcomes-based funding settlement were to take this approach, all those who had paid a defined contribution would be entitled to a sum based on assessed need, rather than paid out according to specific services.

Whilst such an approach would not be able to predict what outcomes people may want to achieve, it would recognise that most outcomes are more costly to achieve if a person has higher levels of need. This would mean that those with the highest needs would have a larger sum to spend on achieving their self-defined outcomes, as they are most likely to require more support in achieving them, without anyone dictating what those outcomes should be. Indeed, by providing funding

⁶ <http://www.pssru.ac.uk/ascot/>

⁷ <http://www.stiglitz-sen-fitoussi.fr/en/index.htm>

independent of prescribed services, such an approach may well incentivise a more iterative, co-produced and personalised outcome-setting process.

This would also be compatible with an insurance model as the premium that individuals would be required to pay would be based on an estimation of the likelihood of having certain levels of need in later life (rather than requirement for a certain service). This would be viable as long as the amount people received according to their need was clearly defined (so actuaries could calculate the cost of the risk and calculate premiums accordingly). This would also ensure the system was transparent for the public.

Of course, the flaws will be immediately evident to those who are already keenly aware of the difficulties of assessing need in a holistic, meaningful way. But there is surely potential to develop an actuarial model that builds up from the best of current knowledge where assessments of needs and definition of outcomes have been co-produced, and where people with lower as well as higher levels of need are empowered to access the care and support they require to enjoy later life.

Conclusion

JRF recognises that combining:

1. fairness;
2. transparency;
3. financial and social sustainability; and
4. capacity to support self-defined outcomes;

into a single care funding settlement is a challenge. Existing models have attempted to define and deliver on the first three, but the fourth remains elusive. No model explicitly recognises the importance of facilitating (ideally incentivising) the achievement of self-defined outcomes – which itself is contingent upon other critical elements being in place (e.g. significantly increased readiness on the part of commissioners, suppliers as well as demand for co-production; a greater understanding of the role of individuals, families and communities in caring and supporting each other; and clarity about the life outcomes to which we can expect to be entitled).

As such many models remain limited by service-based assumptions – whether explicitly or implicitly. This is understandable, given that narrow services are more easily quantified. It is much easier to design a model where a pot of funding is accumulated and entitles a person to a type of service with an associated unit cost. It is altogether more difficult to entitle a person to funding to meet an outcome which may not even fall within a standard definition of social care.

However, an outcomes-based settlement is not wholly out of reach. The key may be to link entitlement to need, which can be a valuable predictor of the costs of meeting outcomes (even if those outcomes are as yet undefined). This has been achieved on an individual scale with personal budgets, and there are a growing number of sources which can help develop a minimum entitlement of outcomes which would form the basis of such a settlement.

We believe it is critical for any funding settlement to start with people's lives – not services, and to facilitate – indeed, incentivise – more positive and progressive approaches to care and support.

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