“A Stain on the Nation”[1]
Care for the Old and Vulnerable in England

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Disclaimer

The views in this paper are personal views of the authors, and are not representative of any organisations to which they are affiliated.

[1] Sir Andrew Dilnot, quoted in the Financial Times, 5th May 2021

ABSTRACT

This paper aims to give a higher profile to that part of the health and social care system that lies outside the NHS. We make no claim to be specialists in the field and we are writing for a non-specialist audience. We believe the wider electorate needs to be alerted to what has been going on for the last four decades in the sphere of adult social care and particularly during the pandemic.

On 29th March 2021, the Government presented a White Paper proposing to 'reform' health and social care, even though the pandemic was still with us and without the benefit of a public enquiry. Yet again, this is dominantly about reforming the NHS and Public Health - with social care to be looked at "later". It is to be a plan for reorganisation of the existing system on "more integrated lines". It is to "formalise the collaborative workarounds that have developed in recent years" It is to be top-down with a Minister in charge. It is going to "remove existing competitive rules". So far it says nothing about resources and funding. There is so much more involved. Another shuffling of the policy deckchairs will not do.

Before yet another move to reorganise the health and social care system takes place, it is essential to go back to basics and to stand back to examine the approach of the last 40 years. We need, for example, to ask the question whether the financialisation and marketisation is the right underlying model for adult social care. Rather than trying to fix a dysfunctional system with further "workarounds", we should at least consider what an alternative approach might look like.

The lessons are there to be learned. We need to open a window on a component of the national system of welfare and wellbeing that, sadly, most of the general population tend only to become aware of when the need for it makes a presence in their lives.

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1.0 Introduction: Setting the Background Context

1.1 The groups most affected by Covid-19

When the full story of the Covid-19 pandemic comes to be written for England, it will substantially be about how it impacted most the older and more medically vulnerable people, those least well off, the BAME population[2], those in the poorest living environments, those in 'front facing' jobs, and those in precarious and low paid forms of work[3]. The virus had its most pernicious effects on those groups least able to find the means to resist it. Of course, younger, better off and generally healthy people were also tragically affected[4] – often taken early from families that needed them - but the heaviest weight of the disaster fell most on the old and the disadvantaged.

In what follows, the focus is on the older age groups and the circumstances in which they found themselves in March 2020. Those who were least well off were those already receiving support from the state through its programme for *adult social care.* To qualify for assistance, they had needed to go through a stringent means test designed to make sure that only those with no private ability to pay were provided with help. This would be through 'paid for' placements in *care homes*, or by being supported at home through state subsidised *domiciliary care*. In March 2021 839,000 people were registered for long term care support in England, across 25,800 provider outlets, at a cost to the Exchequer of £16.5 billion[5].

1.2 An ageing population under a decade of austerity policies

For decades, demographic forecasts had indicated that the demand for long term care was destined to rise steadily across an array of increasingly complex needs[6]. In response to this, however, the number of older people assisted by state funding before the pandemic *fell every year* from 2015-16 onwards. The thresholds that controlled how many qualified for assistance remained fixed for 11 consecutive years – limiting taxpayer exposure to the rising costs of care[7]. Spending by government *was consistently reduced in real terms* - by 49.1% from 2010-11 to 2017-18 (forecast to reach 56.3% by 2019-20[8]). Set against a total of 839,000 in receipt of state support, over *1.4 million new people* submitted claims for support in the single year 2019-20 alone[9]. Clearly, then, while government has kept tight control of its social care expenditure under austerity, older people in need of assistance continued to suffer the consequences. De facto, more

[2] https://www.ft.com/content/0e63541a-8b6d-4bec-8b59-b391bf44a492
[3] https://www.bbc.co.uk/news/health-56334982
[4] https://www.resolutionfoundation.org/publications/intergenerational-audit-uk-2020/
[5] Part of the difficulty in understanding how this is spent is revealed in this telling comment from the NAO: *"Under the Care Act 2014, the Department (DHSC) does not have legal powers to intervene or hold individual local authorities to account for their performance. In February 2021, the Department published its legislative proposals for a Health and Care Bill, which include plans for gathering more information on social care and would give CQC new duties to review and assess local authority performance".*
[6] http://www.cer.org.uk/publications_new/790.html
[7] https://www.theguardian.com/profile/chaminda-jayanetti
[8] https://www.nao.org.uk/report/adult-social-care-at-a-glance/
[9] https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20

and more of the costs of support have been thrust onto the older age groups, and on the families who support them.

The number of people actually receiving state assistance is very small in relation to the size of the nation's older age population. There were estimated to be around 12.4 million people over 65 in the UK in 2019[10]. Many of them benefit from the legacy of better times when they could build up the asset value of their homes and sound occupational pensions. The government's triple lock pensions policy[11] also plays strongly in their favour. As a result, significant numbers are in a position to pay privately for home care or care home placement from their pension, savings or through equity release from their homes[12]. The most well-endowed can afford residential care costs often costing more than £1,000 a week[13]. This supports a currently buoyant marketplace for private sector care provision.

However, a substantial proportion of the older population needing support falls between the two extremes. They are neither poor enough to qualify for state support nor rich enough (both personally and in family terms) to finance self-payment. This set has generally to depend on a mix of paid home care and informal care from family or friends. Before the pandemic, the charity Carers UK estimated around 7.3 million people from among family, friends and neighbours[14] were providing care informally and unpaid[15]. The 2021 Census will tell us more about this when the results are published, but Carers UK estimate that 1 in 8 of us are carers, and "*Carers save the economy £132 billion per year, an average of £19,336 per carer*"[16]. Presented with a pandemic, all three groups – state assisted, self-paying and informally supported - were faced with potentially devastating but differential problems.

In the early months of 2020, much was reported about the excess deaths among those in the care homes. Much less widely known were the tragedies unfolding in the context of home care, and at home with informal support. Fatal outcomes here were generally assigned to the hospital category and not distinguishable by their care context. In the realm of informal care for those having to depend on family, the way social distancing and travel restrictions for carers had an impact on infections and deaths was hard to estimate. It was, perhaps, not just for epidemiological reasons that the numbers of deaths in the older age groups was so excessive. The pre-existing system of social care played a not insignificant role.

1.3 A flawed system in place

For the least well off among the older age groups, a lack of government financial support was one problem, but the way the adult social care system was structured was another. Its inadequacies had been acknowledged for decades. The Conservative-Liberal Coalition Government accepted it as a significant issue and had moved to reform it[17]. Under Lansley and the Care Act of 2014, draft legislation was even put in place - but it did not make it to the Statute Book. The story was the same just before the pandemic. In 2019, Boris Johnson as the new Prime Minister, acknowledged the problem and promised early reform.

[10] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2019estimates

[11] https://commonslibrary.parliament.uk/research-briefings/cbp-7812/

[12] https://www.moneyadviceservice.org.uk/en/articles/using-an-equity-release-scheme-to-fund-your-care see also https://rgs-ibg.onlinelibrary.wiley.com/doi/10.1111/tran.12410

[13] https://www.carehome.co.uk/advice/care-home-fees-and-costs-how-much-do-you-pay

[14] "*166,363 of the carers in England are children*" https://psnc.org.uk/services-commissioning/essential-facts-stats-and-quotes-relating-to-carers-and-providing-carer-support-services/

[15] https://www.nao.org.uk/wp-content/uploads/2021/03/The-adult-social-care-market-in-England.pdf

[16] https://www.carersuk.org/news-and-campaigns/press-releases/facts-and-figures

[17] https://www.nao.org.uk/wp-content/uploads/2021/03/The-adult-social-care-market-in-England.pdf

Two years later, post-pandemic, we have a White Paper that is dominantly about the reform of the NHS - but with plans for social care reform to come later. As the Guardian of 23rd March 2021 put it:

> "*Successive governments have promised and failed to deliver reform of adult social care for years, despite cross-party support. Johnson himself said he had a "clear plan" to do so when he became prime minister in 2019, but has yet to deliver one"*[18].

This, then, is where we found ourselves when Covid-19 arrived early in 2020, with a broken system widely recognised but still in place. Early on, it became clear that the virus was having a lethal impact. The Office for National Statistics (ONS) reported that, by 29 May 2020, more than 46,000 people had died from coronavirus in England and Wales. Data up to 9th May showed that there had been 45,899 deaths from all causes assigned to care home residents and, of these, 12,526 involved Covid-19. Over the first two waves of the virus, the over 70s age group in care homes was badly hit with most deaths among the over 75s.

Something was going badly wrong, and the arrival of the ONS data finally triggered a recognition of the problem[19]. What could not be so easily counted was the number of those outside the care homes receiving domiciliary care support whose lives had been shortened by the virus. We had found ourselves with a system of care that was not only systemically ill-equipped to cope with such a traumatic event but one where lack of recognition of the ongoing crisis led to even the most basic means of infection control – masks and gowns – being in desperately short supply.

Far too little is known about what actually happened to the wider cohort of older people in our society on the advent of Covid-19, and it is our ambition to shine a better light on it. What follows suggests that a significant key to the lack of resilience in the care system arose from a *30 year old model of largely privatised provision* derived from the Thatcherite ideology of the 1980s. While those who work in adult social care performed heroically and with great ingenuity to keep things going during the pandemic, the system itself was structurally and financially incapable of responding to such a crisis. However, to see where the base structure of that system came from, we have to go even further back - to the very first steps taken after the war to introduce the NHS.

1.4 Structural segmentation: Health care versus social care

The NHS is a much valued health system 'free at the point of use'. In many ways it remains the envy of other countries. But the obvious problem with such an all-embracing position has always been that expectations are hard to meet in practice. Matching (finitely funded) supply to (unconstrained) demand was going to be a problem, and some form of matching is attempted through a series of 'demand and capacity' models[20]. Inevitably, some boundaries had to be drawn as to where 'free of charge' operated and where it stopped. In this respect, a highly significant boundary was erected in 1948 between "health" care inside the newly created National Health Service and those forms of care deemed to lie outside it. On this basis a category of national public policy came into existence called *social care*[21]. This was assigned to the local

[18] https://www.theguardian.com/society/2021/mar/25/lack-of-social-care-strategy-left-system-weakened-when-covid-struck-report

[19] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsinvolvingcovid19inthecaresectorenglandandwales/deathsoccurringupto1may2020andregisteredupto9may2020provisional#characteristics-of-care-home-residents-who-died-from-covid-19

[20] https://www.england.nhs.uk/ourwork/demand-and-capacity/models/

[21] NICE (mentioned above) covers both parts of the binary divide https://www.nice.org.uk/about/nice-communities/social-care

authorities to deliver - perhaps on no better an assumption that this had been the case since Tudor times and the Poor Laws.

While the health care and social care context of the nation has changed out of all recognition since that time, this binary separation has remained in place. The policy premise has been that it is possible administratively to distinguish between a person's care needs that are somehow about health and somehow, quite distinctly, about something else called social care. We have lived with this split for so long that its genesis is often forgotten, but for the old, the frail and the cognitively impaired, practical 'care' is, as a matter of common sense, an *integrated process.* It normally contains hard-to-separate aspects of both the medical and the social components of health, and it is closely tied to issues of dignity and well-being in later life, leading to what the Lien Foundation has termed a *Quality of Death Index*[22]. For a comprehensive review of the history of adult social care see (Gray & Birrell, 2017)

1.5 How dementia is positioned

A classic current case that illustrates a major problem with the binary distinction is *dementia.* This is a syndrome[23], the incidence of which was hardly recognised in 1948, but that now afflicts around 850,000 people across the UK and is projected to grow rapidly over the next decades[24]. Under the rules for NHS 'free at the point of use' support, dementia is categorised as not representing a primary health need. For the purposes of welfare policy, a person's *health needs* – not their diagnosis - determines whether they are eligible for funding. By this device, having a *diagnosis of dementia* does not bring an entitlement to free NHS care[25]. The Alzheimer's Society has a particular view on this:

> *"…the health and social care system discriminates against people with dementia. Despite dementia being a medical condition, the needs of people with dementia are often seen as social care rather than healthcare needs. As a result, thousands of people with dementia spend substantial amounts of money on social care they need as a result of their medical condition"*[26].

Under this arrangement, dementia sufferers and those who care for them are routed for assistance into *adult social care* unless they have another health related co-morbidity, or a condition that can qualify them for NHS Continuing Health Care[27](Department of Health, 2012). The increasing weight of claims for adult social care assistance clearly has much to do with the fast growth in the numbers of people suffering from dementia and other forms of cognitive impairment. This is in the face of the 11-year decline in the amount of state assistance on offer for social care.

By any measure, something is not right, and for more than a decade it has been acknowledged to be so. It is not just a matter of state support, there is an accompanying perception problem. The categorisation of dementia as not being a primary health need can spill over into the way it is perceived inside wider health community[28].

With a progressively ageing population, and a continuing rise in dementia cases, a growing share of the population (both sufferers and carers) is having to live with this questionable and arcane distinction. The

[22] https://www.lienfoundation.org/project/quality-of-death-index-
[23] https://www.nhs.uk/conditions/dementia/about/
[24] https://www.dementiastatistics.org/statistics/numbers-of-people-in-the-uk/
[25] https://www.continuing-healthcare.co.uk/continuing-healthcare-guidance/chc-funding-for-dementia
[26] https://www.alzheimers.org.uk/about-us/policy-and-influencing/what-we-think/nhs-continuing-healthcare
[27] https://www.nhs.uk/conditions/social-care-and-support-guide/money-work-and-benefits/nhs-continuing-healthcare/
[28] The acute sector experience of one the authors with a wife suffering from dementia leads to this conclusion.

financial burden of a fast-growing need for complex dementia care has been supported for decades through the *adult social care budgets of the local authorities*. De facto, dementia was assigned to precisely that part of the public domain cut most savagely under the Conservative austerity programme after 2010. This placed the vast majority of sufferers and their families in a position where they either find a means to finance high-cost self-payment or have to depend on family and friends for home support. Savings have been stripped and home-based family pressures exacerbated. While we now know a great deal about the struggles of the care homes under the virus, the story of those whose loved ones have dementia, and who had to cope with the stresses of having cognitively impaired relatives at home, is yet to be fully revealed.

1.6 Social care – marketized, complex and little understood by those outside

Why then, in the face of what has just been said, has the issue of social care in general and dementia care in particular, been so low on the wider public agenda around Covid-19? There are many reports of staff struggling to cope in the hospitals and 'save the NHS' has been a standard political mantra. But much less has been reported about the struggles of care home or domiciliary care staff, or informal carers at home. While the NHS carries enormous significance for the UK electorate and the political class and is a national body with clear and highly valued profile, its administratively separated and poorer relation *adult social care* is much less visible.

Adult social care is split up across the 150 higher tier local councils. It sits alongside Disability Benefit, Incapacity Benefit, and Benefits for Carers, as part of the nation's means tested social care programme. Most local taxpayers will only see it as an expanding precept in their annual council tax bills. Adult social care is, however, a major part of what higher tier local authorities do as a statutory requirement - with 30-40 percent of their drastically reduced budgets. This brings local politics strongly to bear in the context of what is essentially a nationally mandated public welfare service (Ellis, 2015) .

Another reason for the low profile of adult social care comes from the fact that, under its 1990 design, care is delivered almost exclusively at arms-length by *private sector players* under commercial contract arrangements (NAO DHSC, 2021). While privatisation plans for the NHS over the decades faced resistance and did not go so far, adult social care was subjected, at a stroke, to full conversion to an independent provider market model under the 1990 *National Health Service and Community Care Act*[29].

This turned local councils from being service providers into 'enabling authorities', requiring them to spend 85% of their funding on purchasing care services from the private sector. The fact that some key components of care needs the providers to act, not in competition with each other but *in close co-operation* was under-emphasised at the outset. To cope with this, fix after fix had to be regularly applied - creating an alphabet soup of acronyms for various workaround activities.

Another feature of the market-facing approach was to introduce more *individual choice.* This was again consistent with a 1980s ideology that favoured the individualisation as well as the privatisation of the public service offer. Public goods were to be delivered as if privately valued and this saw the introduction of things like self-directed support, personal budgets, and direct payments (Carr, 2012). These were seen as "*sitting uneasily alongside the practices of assessment, support planning and personal budget (PB) allocation for older and disabled people*" (Glendinning, Mitchell, & Brooks, 2015). Yet another layer of complexity was added to the social care system. No wonder the system for adult social care is opaque to virtually

[29] https://www.legislation.gov.uk/ukpga/1990/19/contents

everybody, until they or somebody near them actually needs its services and has to navigate its labyrinthine pathways.

The political result of this purchaser-provider system design was that adult social care was placed 'two moves distant' from any *national political accountability* for what was going on – first down to the local authorities and then out to private contractors. Care for older and vulnerable people has been consigned for decades to a money-based competitive marketplace organised by local council "*market-makers*" [30]

1.7 An under-funded system without resilience faces Covid-19

When Covid-19 arrived in March 2020, it could be no surprise that social care lacked the flexibility and resilience to cope. The King's Fund made the following observation on 16 July 2020[31].

> *"The social care system is not fit for purpose and is failing the people who rely on it, with high levels of unmet need and providers struggling to deliver the quality of care that older and disabled people have a right to expect. These combine to place great pressures on families and carers. The Covid-19 epidemic has exacerbated many of these problems, including increasing levels of unmet need and further destabilising the already fragile care provider market"*

Somewhat later, on 22nd October 2020,the Parliamentary Committee for Health and Social Care in its report, 'Social care: funding and workforce', opened with the following statement[32] :

> *"The Covid-19 pandemic has thrust the long-recognised crisis in social care funding into public consciousness. The case for reform of the system accompanied by adequate funding, whilst long supported by this and other committees, has therefore never been more urgent or more compelling".*

As is now clear, the largest number of deaths and the worst outcomes from the virus were experienced by the old and the most disadvantaged. Of course, Covid-19 had a particular pattern of health outcomes arising from the infection itself. It singled out older and more vulnerable groups for its worst effects. But this fell on a system already known to be ill-equipped to cope even in normal times. In what follows we aim to offer a non-specialist audience a better understanding of how adult social care works, before going on to look in more detail at what happened under Covid-19. Along with the NAO, we accept that there is an overwhelming need post-pandemic for a *complete re-thinking of the model*[33]. Adult social care needs to move away from its 1980s privatised and arm's length design if a post-Covid-19 disaster is to be avoided.

[30] https://www.gov.uk/government/publications/adult-social-care-market-shaping/adult-social-care-market-shaping
[31] https://www.kingsfund.org.uk/publications/covid-19-road-renewal-health-and-care ((updated on 8 April 2021)
[32] https://committees.parliament.uk/publications/3120/documents/29193/default/
[33] https://www.nao.org.uk/wp-content/uploads/2021/03/The-adult-social-care-market-in-England.pdf

2.0 Adult Social Care

2.1 A system in two parts

Adult social care is essentially the domain of those who, for one reason or another, cannot pay the full costs associated with their need for care outside the scope of the NHS. There are two distinct components as detailed by the Competition and Markets Authority in November 2017:

1) *Accommodation and personal care provided in residential care homes and nursing homes. In 2017 the care homes sector was worth around £15.9 billion a year in the UK, with around 410,000 residents. Local authorities commission care services from independent care providers dominantly in the private-for-profit sector. Property assets are a vital component of the business model for the private sector providers.*

2) *Personal care provided in the community (at home) dedicated to "helping frail and older people stay healthy and independent, avoiding hospital stays where possible" (NHS England 2017b). This covers around 350,000 people with a total expenditure of around £2.5 Billion. Commissioned by local authorities, it is delivered through independent (mostly private) providers on a "task-and-time" contract basis".* [34]

Combined together, these two account for around 25,000 organisations and provide jobs for a workforce of around 1.65 million. In 2016-17, around 75% of people who received either short- or long-term social care services received support in their own home. This amounted to around 48% of total expenditure on short- and long-term care services arranged by local authorities[35]. An immediate take from this is just how large adult social care is as a component of the nation's economy and employment. It accounts for over 3 percent of the nation's workers and ranks alongside Food and Drink, and Public Administration and Defence, as comparators in numbers employed. Interestingly, also the total number of people it serves is on a par with the NHS. Adult social care is, by any measure, a major contributor to national well-being.

2.2 Austerity exacerbates geographical variation

As a specially constructed marketplace for private business providers, adult social care had mixed fortunes over the last two decades. The UK budget for care had risen by 5% year between 2001 and 2010 to peak of £18 billion before it fell back sharply under the Osborne austerity programme. By 2016, funding was back to the 2001 level at £16.8 billion as local authority funding was sharply curtailed. Overall, this represented an 11 percent fall in the available funds per person - at a time when the population was ageing and demand was steadily rising (Glasby, Zhang, Bennett, & Hall, 2020).

These funding cuts were not even in their distribution. A complex system of distributed funding makes it difficult to ascertain how far adult social care funding maps onto other forms of disadvantage. The Institute for Fiscal Studies, however, notes that in 2009-2016: *"cuts in expenditure have been far larger, on average, in London (18%) and the metropolitan districts (16%) covering other urban areas such as Greater Manchester, Tyneside and Greater Birmingham, than in the rest of the country*". *Outside these areas, cuts*

[34] https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf

[35] https://www.nao.org.uk/report/adult-social-care-at-a-glance/

have been larger in the north of England than the south, on average[36]. Many local authorities worked hard to maintain spending from their own resources where they could, but this was often at the expense of other programmes in the local political context.

The scale and shape of the private market for adult social care shows, then, distinct *place to place variations*, and the variations map on to the regional and local wealth in general (Phillips & Simpson, 2017). Even in good times there has generally been a postcode lottery for both providers and service users but this became further exaggerated under austerity measures For example, in 2017, Laing and Buisson showed a gradient in the availability private funding provision from 61.9 percent in the South East to 21.9 in the North East[37]. In effect, those areas that needed the funds suffered most heavily from the cuts while being less able to attract private payers. We are, then, looking at another component of the north-south divide. "Levelling up[38]", so far constructed as an economic development programme, should not just be about infrastructure spending and regeneration.

2.3 Provider business consolidation in the market for residential care

Some 25,000 independent providers are involved in the delivery of adult social care. The vast majority of them are small but around fifth of the total market involves large providers operating through investment funds (Burns et al., 2016). By design, the bulk of the provision comes from for-profit private businesses with the remainder from the VCS. Increasingly, the larger providers – particularly in residential care - are consolidated into major chains operating under a corporate brand[39]. Residential care tended originally to be colonised by small 5-10 bed businesses using older multi-room housing stock but now much of the new provision is in homes with 50+ beds under a hotel-style format. The older homes are having increasing difficulties with the need to renovate old stock while the newer, larger ones are turning to large scale new build developments.

New forms of ownership in the residential care sector have made it easier for private investors to enter the market. REITs (Real Estate Investment Trusts) have become increasingly popular. REITs are a tax efficient form for liquid securities that can be bought and sold on the global capital markets. The funds seek to drive their value from both the assets of the residential property (appreciation/sale) and from the securitised value of the stable income stream that comes from care fees. Offshore equity plays a significant role. While a REIT may be beneficial for owner-providers and a means to secure finance for the development of residential care homes, a concern is that the ultimate ownership of homes can be opaque[40].

There are some questions here for risk, resilience and sustainability. Residential care is a key component of the nation's welfare programme as well as a development opportunity in a marketplace for privately purchased care. It has become closely associated with the commercial development sector with new premises constructed and sale and leaseback arrangements to care home operators. The costs of private placement for long term residential care are high and above inflation, upwards only annual reviews are normal. How appropriate this is for providing a key component of the nation's welfare – especially in times

[36] https://www.ifs.org.uk/publications/9122

[37] Laing and Buisson, *Care of Older People: UK Market Report*, 28th Edition, May 2017.

[38] And this controversial fund had a controversial methodology for allocation of funds https://www.gov.uk/government/publications/levelling-up-fund-additional-documents/levelling-up-fund-prioritisation-of-places-methodology-note that underplayed deprivation https://www.lgcplus.com/finance/levelling-up-fund-methodology-criticised-as-a-fudge-12-03-2021/

[39] https://hummedia.manchester.ac.uk/institutes/cresc/research/WDTMG%20FINAL%20-01-3-2016.pdf

[40] For example, look at the UK Government examination of the ownership structure of the failed Four Seasons Group (section 2.3) https://researchbriefings.files.parliament.uk/documents/CBP-8004/CBP-8004.pdf

of crisis – is something that needs close examination (Burns et al., 2016). A significant downside of the model of large scale corporate provision is that closures, where they occur, can have devastating effects on local communities[41]. While business risk is priced in for the providers, the wider risks associated with firm failure or withdrawal are externalities borne by the public sector where the local authorities have a mandatory duty to deal with this under the 2014 Care Act.

A significant share the finance underpinning demand in the adult social care marketplace comes from public funds through the local authority commissioners[42]. Their mandate is to maximise the scale and scope of social provision under the guidance of the Care Act - while the Care Quality Commission[43] (CQC), as a national body, maintains quality standards[44]. Against the funding pressures outlined earlier, additional funding to deal with innovation and quality improvement has tended to be provided in the form of externally funded add-ons and fixes (*Better Care Fund[45], Skills for Work[46]* and so on). Despite this, however, the general narrative is that margins for providers are always tight - demanding close costs management particularly for the wage bill. Before the pandemic, this tended to be borne out by the scale of closures and there is every prospect that in recovery this will continue unless better funding is secured [47] [48].

2.4 A market too far in the sphere of welfare

While the thrust of the privatisation model from 1990 was 'market making', the supply of adult social care as a locally supplied public service is far removed from a classic market. There is, for example, no down-sloping demand curve with open and flexible suppliers competing with each other to achieve an equilibrium price. The core prices are primarily pre-set and being drawn from scarce public funds, they are likely to be always under pressure. Private-for-profit suppliers have to determine how they can operate within the contract arrangements negotiated annually with the local authorities and this can incentivise them to turn toward exclusively private payment provision.

The choices for customers in this context are limited by available supply as well as by public funds. Market knowledge is limited and many of the customers are constrained in switching (dementia sufferers for example). The literature is full of dire warnings about "*tipping points*" (Keogh, 2016), market failures (Hudson B , 2016), (Hudson B, 2015) and a "*lost decade of warnings*" (Glasby et al., 2020) for a privatised system that struggles to serve a growing population of older vulnerable people. But, as CHPI points out:

> *"For governments looking to reduce the scale of state spending there is one clear upside to all of this – the shifting of capital expenditure from the Treasury and local authority balance sheets to the*

[41] The collapse of Southern Cross, with almost 10 percent of care home provision in 2011, In March 2019, Four Seasons too went into administration. Between 2015 and 2017, three of the biggest national providers of home care (Saga, Care UK and Housing & Care 21) withdrew from the publicly funded home care market. Mitie after reporting losses subsequently sold its home care business for £2 (see: Kings Fund, *Homecare in England Report*, 2018, https://www.kingsfund.org.uk/sites/default/files/2018-12/Home-care-in-England-report.pdf)

[42] https://www.scie.org.uk/publications/guides/guide45/prevention.asp

[43] https://www.cqc.org.uk/

[44] Of course, there is a genuine market for care from among those with the level of resources needed to enter it. Care home providers and home care businesses can either serve this market exclusively or operate in mixed mode.

[45] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/better-care-fund/

[46] https://www.gov.uk/guidance/plan-for-jobs-skills-and-employment-programmes-information-for-employers

[47] https://www.theguardian.com/society/2019/mar/11/over-400-care-home-operators-collapse-in-five-years-as-cuts-take-toll

[48] https://www.caremanagementmatters.co.uk/rate-of-care-home-closures-in-england/

private sector. The industry estimate is that this investment now amounts to a cumulative total of around £30 billion and has resulted in the creation of over 350,000 beds in care homes".[49]

With arrival of the pandemic and its disastrous outcomes for the old, this national balance sheet advantage should be exposed to closer moral scrutiny where the provision that emerged out of it created a system in no position to respond to normal conditions let alone a catastrophic crisis of care.

The downside of the market-based system that ranges across both poor localities and rich is that it is itself *a generator of inequalities*. On top of this, placing local authorities in a position where what they can spend on social care is pitted against the other calls on their budgets is pre-loaded against the poorest places. For a nation with among the highest rates of inequality in the G7[50], adult social care in its present form is an additional contributor to socio-spatial inequalities .

2.5 A market too demanding in the private sphere

As we have just discussed, there is a more orthodox market in play for those people able and willing to pay directly for care. Indeed, for the bulk of the population this is where they have to go to secure support. The base assumption of the care system is that the population will generally be expected to provide for personally or pay commercially for the support they need[51]. This private market for self-payment is, in part, a more recognisable one. Individuals exercise their competing claims in a local care marketplace. For-profit providers come into play to satisfy their needs at a price determined by costs and by the competitive context in the local marketplace – but as we have seen there is a lot more to it than that.

For long term residential care, the choice of a care home often tends to be relatively fixed in place over the life of the resident – in effect representing a *captured premium market*. The aim of the suppliers is to maximise returns to their shareholders. Given that much of the care to be purchased tends to be long term, this leads on to considerable claims on private household resources. It can involve the commitment of virtually all lifelong savings and ,in a significant number of cases, this follows through to the release of equity from homes. This "captive marketplace" raises critical questions about the way prices are set and how they inflate over time. Private purchasers of care can find themselves trapped into a one-way-street of high and rising costs in caring for their loved ones[52]. Given what was said earlier about corporate structures in the private care market, this opens the door to a direct transfer of asset wealth from care home consumers to the offshore financial marketplace.

It was the sheer weight of this situation for private payers for care (with its potential electoral consequences) that drew the government of the day into action in 2010. With a brief to balance both sides the issue (public and private), the economist Andrew Dilnot was commissioned by the Conservative-Liberal coalition to chair an independent review[53]. He was tasked with making recommendations for changes to the funding of care and support (defined as; services that help frail and disabled people remain independent, active and safe) in England. The brief was to grasp the nettle of state versus personal funding for social care and to make recommendations for a balanced resolution.

[49] https://chpi.org.uk/wp-content/uploads/2016/11/CHPI-SocialCare-Oct16-Proof01a.pdf
[50] https://www.equalitytrust.org.uk/scale-economic-inequality-uk
[51] The average cost for a care home self-funder in 2016 was £846 per week (nearly £44,000 per year), while LAs on average paid £621 per week". Private care homes fees have risen to over £1000 a week, £50,000 plus in 2021.
[52] This is the direct experience of one of this paper's authors (£52,000 a year rising annually by 5%).
[53] https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/briefing-dilnot-commission-social-care-jul11.pdf

The issue was the burden of the care costs faced by people with assets over £23,250[54] - the then and now limit of assets above which state funding was not available. The problem for the state was to limit the call on the public finances at a time of financial crisis. Another desired outcome was to find a way to create the conditions for the creation of a market to develop for financial products so that people could insure themselves against the cost of their possible future liabilities. Dilnot ruled out insurance as a viable alternative. The issue is one for government.

In walking this tightrope, the Dilnot Report, released in July 2011, concluded that individuals should pay only the first £35,000 of their care if they have more than £100,000 in assets. Beyond this limit, the state would pick up the costs of care. People living in a care home would have their ongoing living costs capped at £7,000-£10,000 per year. Outside these arrangements, the government would provide *free social care with a national threshold for care eligibility across all councils to remove the existing local variabilities*. The findings of Dilnot were, tragically, never implemented despite being welcomed by the then health secretary Andrew Lansley and the opposition. They were incorporated into the 2014 Care Act, subsequently amended and then withdrawn. We find ourselves once again, after 10 years, waiting for a government statement on the care cap – both at the bottom and the top – but current commentators are of the view that the issue will be dodged again[55] [56].

2.6 The conditions for workers in adult social care

There is another feature of the marketplace for social care that has wider negative consequences both inside and outside the arrangements for social care itself. In 2020, as noted above, adult social care provided employment for a workforce of around 1.65 million (1.2 million FTE)[57]. It tends to be dominantly female (83 percent), regarded as low skill (in the sense of formal qualifications at least), and in many areas is attached closely to the BAME community (21 percent of its employees). The workers tend to come from marginal communities, often bringing in those who need to find work regardless of the low pay and its demands upon them.

In job terms, the sector grew by 22 percent between 2009-2017 and added a further 19,000 jobs (1.2 percent) between 2017 and 2018. Around a quarter of the adult social care workforce were recorded as being employed on zero-hours contracts. Within this, 43 percent of those in domiciliary care were on zero-hours contracts. Unsurprisingly, given this situation, annual staff turnover was estimated as 30.8 percent in 2017-18 (Skills for Care, 2019). On average, wages for care workers sit close to, or below, the National Living Wage - around £8.50 per hour in 2020. Contacting arrangements, however, serve to hide the reality. Real pay rates may be much lower. All this is despite the fact that the work is both intensive physically, and emotionally demanding. The care sector is chronically short of labour under these terms and conditions with currently over 112,000 vacancies[58] (recognising these staffing gaps the government provided £120 million in February 2021 to help local authorities support care providers).

[54] With some variations https://www.moneyadviceservice.org.uk/en/articles/local-authority-funding-for-care-costs-do-you-qualify

[55] https://www.theguardian.com/commentisfree/2021/may/07/real-social-care-reform-england-tory-government

[56] https://www.ft.com/content/a9fea0a7-cb3e-4ee5-8008-b0b1e3a5074f

[57] *The State of the Adult Social Care Sector and Workforce in England, Oct 2020* https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2020.pdf

[58] https://kingsfundmail.org.uk/21A8-7CWI5-4460BE75CBD80CFB62L85J8D39C44F42CBEA8F/cr.aspx

A large and growing segment of the national labour force is, thus, finding its way into employment in social care. For many at risk of unemployment, this is a routing that starts from the job-search rules of Job Seekers Allowance (JSA). While the employers responsible for the terms and conditions of the workers are independent private sector businesses, the funds that create the market in which they operate come significantly from the state and taxpayer funds. The Kings Fund in 2020 put this in simple terms: *"The money flows – in crude terms – from national government to local governments (who commission services), then to providers and only then to care workers"*[59].

At the end of this public money flow chain, an increase in central social care funds may not even make it to the care workers on the front line. And yet these are those 'frontline workers' for whom the nation clapped in the worst days of the pandemic, and those responsible for the hands-on care of the most vulnerable. Rooted to the National Living Wage (if they can even receive it) and recently capped (as opposed to employees in the NHS) these are people who surely deserve better.

The colonisation of the UK labour market by low wages and zero hours contracts has attracted widespread concern across the board as it can commit increasing numbers of households to a life of precariousness (Adams, Freedland, & Prassl, 2015) (Kalleberg, 2009). Most of this literature is on topics like the 'platform' and 'gig' economies and the effects of technology and internationalisation. The labour market for social care should be included as part of this set. The Social Care Regulation at Work Group at the University of Kent offers an excoriating critique, even suggesting that; "*care workers are at 'high risk of labour exploitation' based on evidence gathering by enforcement agencies. This builds on earlier reported concerns about forced labour and exploitation in social care*"[60]. We find ourselves in 2021 in a situation where low pay, zero hours contracts and agency working are accepted as the norm for more than 1.6 million workers in a state-funded but privatised system of social care created 30 years ago. The government has promised reform of the system (better integration), but not of the model and its outcomes for workers.

2.7 Multiple negative circularities for local places

A significant feature of the labour market for adult social care labour is that it tends to be *highly localised* with short travel to work distances the norm. The average rate of staff turnover is around 33 percent, but rates can be as high as 40 percent in poorer localities. Workers tend to move within both the sector and the locality with around 66 percent of moves of this type and recruitment and retention is a standard challenge for employers in the sector[61]. As noted above, the poorest regions and localities are those where the cuts in council budgets had their greatest impact on funds under austerity. By definition, these places are where the demands on the local authorities are the highest and where adult social care has to compete with many other calls on spending.

These are also localities where the top-ups available to providers from self-payment are at their lowest. For private margins to exist under these conditions, wages inevitably have to be close to the accepted minimum and contracts flexible. While care jobs are in some cases the only ones available, their conditions may well add to - and certainly not ameliorate – existing conditions of precarity. On this basis, a locality can find itself

[59] https://www.kingsfund.org.uk/blog/2020/12/careworker-pay-national-living-wage-not-enough
[60] https://research.kent.ac.uk/social-care-regulation-at-work/insecurity-low-pay/
[61] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/State-of-Report-2019.pdf

locked into a 'low-level skills equilibrium'. This is where an economy becomes trapped in a vicious circle of low value added, low skills and low wages[62].

Under these conditions, the implications of what happens where the care sector plays a major role in disadvantaged places can go much wider than the sector itself. What we can see from all this is evidence of *multiple circularities* with their greatest impact on the poorest places in the country. Where care workers are those for whom face-to-face and intimate contact is a necessary part of the job, and where many have to travel on public transport. This is also a cohort of workers where the option to isolate and not go to work if infected may well play out in households already in precarious circumstances. There is a bleak coincidence between Covid-19 rates of infection and those localities where a large share of the population finds itself already employed in the adult social care sector. We are looking at a system with strong *locally polarising* features. Geography matters, and central reforms that do not recognise the local context will be doomed to fail.

2.8 A system on the cusp of collapse

As noted in Section One. adult social care was a system that, even before the pandemic, could be seen as failing not just those being supported under its auspices, but a wider population of older and vulnerable people and their families whose life saving and assets were being unreasonably stripped away at a rate even the government had earlier admitted was beyond reason. Those employed in the system were also badly served by wages and terms and conditions among the worst in the country. Many private businesses in care homes also struggled to survive[63]. In the year before the arrival of the pandemic, there was a net loss of 149 care homes[64]. Post-pandemic occupancy rates have fallen to 80 percent providing a business challenge to many operators[65]

Five years ago, Bob Hudson had already described it adult social care as; "failed and fragmented" (Bob Hudson, 2016). In *The Guardian 31st July* 2020 he repeated this message, describing the situation thus:

> *"There is little disagreement that social care is on the cusp of collapse – it is failing to meet the needs and requirements of commissioners, providers, the workforce, users and carers. Proper funding is most certainly needed to resolve this predicament, but it is also clear that social care itself needs a new vision"[66].*

A critical question for the electorate might be whether this 30 year old model based on a binary distinction between NHS health care and social care meets a fundamental social requirement for society to provide reasonable conditions for its older and more vulnerable citizens. From the view of the workforce there is a different question to be asked: does the system in place fairly reward the people for the contribution they make? These are big questions we shall return to in the conclusion. Sadly, it seems this is not an issue that touches the consciousness of the nation. Perhaps the disappointing truth is that, for the electorate at large, conditions in adult social care only take on relevance at the point where there is a need to engage with it for oneself or a loved one.

[62] https://warwick.ac.uk/fac/soc/ier/publications/2003/wilson_et_al_2003_low_skills.pdf
[63] https://www.nhsforsale.info/sector/long-term-care-new/
[64] CSI Market Intelligence 2020, Say hello, wave goodbye: 5th annual report. The latest 6th annual report is at https://csi-marketintelligence.co.uk/shwg.html
[65] https://kingsfundmail.org.uk/21A8-7CWI5-4460BE75CBD80CFB62L85J8D39C44F42CBEA8F/cr.aspx
[66] https://www.theguardian.com/society/2020/jul/31/handing-budgets-nhs-social-care-collapse

At this point we turn to the pandemic and to the way in which the arrival of a deadly virus emphasised the weaknesses in a system of social care that all believed was in need of serious reform[67]. To emphasise the point no less a figure than Sir Andrew Dilnot himself was quoted in the Financial Times (5th May 2021) as having said that the failure to follow through with reform was a *"stain on our nation"*[68]. Against all this, it has to said that, while the outcomes from the pandemic were in many ways catastrophic, the virus unleashed a wave of goodwill and creativity that served to take the edge off many aspects of the impending disaster..

[67] https://www.prospectmagazine.co.uk/policy-money/the-nhs-has-faced-a-public-health-catastrophe-compounded-by-a-decade-of-cuts

[68] https://www.ft.com/content/a9fea0a7-cb3e-4ee5-8008-b0b1e3a5074f

3.0 The Arrival of the Pandemic

3.1 The evidence now emerging

We are now seeing the build-up of an enormous of literature looking back at the pandemic experience of those older people in care homes and those being supported at home by state funded domiciliary care and by unpaid family carers.. A simple key word search brings up some 13 pages of references on the issues of care homes under Covid-19 (Oliver, 2020), (O'Neill, 2020), (O'Dowd, 2020), (Emmerson et al., 2020), (Burton et al., 2020), (Bowman, 2020), (Daly, 2020) to list some that helped us most. This is not the place to make an attempt at a literature review. What is needed, and will surely come, is a Cochran-style Systematic Review. We have set ourselves to tell a longer story of which the pandemic is just the tragic endgame. To this end, we crave the forgiveness of those whose work we simply attach to our central theme of a failing system badly exposed by events.

The emerging themes from the Covid-19 story are very much the same – poor preparedness, low resilience, lack of PPE, staff shortages and pressures, confused central messaging and an inability to isolate residents from infection. A key driver at the beginning was the transfer of untested patients to and from hospital during the first wave . It was not just about residents and care-receivers, it was about those working in the care sector, many of whom ended up sacrificing their lives as they continued to support residents and clients..

3.2 The situation in adult social care

3.2.1 An outsourced and largely privatised system in crisis

The model we have described in previous sections – outsourced, underfunded, fragmented and under-staffed – set the scene for what quickly unfolded. It was some way into the pandemic before government was fully aware of what was going on. It took two months until better data arrived and the shocking scale of care home deaths became evident before government and the nation were jolted into paying attention[69].

The adult social care system was not put together with considerations of a possible health emergency in mind. Resilience was not a system objective. Such risk as was factored in was business risk and the sorts of day-to-day risks covered by standard insurance. This was also the case across the privatised elements of the public service, from schools to prisons, to transport. The risk of failure for the system as a whole in the face of an emergency was a matter for the state. This was no trivial matter. for a sector costing around £17Bn in the year before the pandemic. Taking a view in March 2021, on care sector expenditure during the pandemic the National Audit Office stated:

> *"The Department currently lacks visibility of the effectiveness of care commissioned and significant data gaps remain. As such, it cannot assess the outcomes achieved across the system and whether these are value for money"*[70].

It appears that we do not know enough about the social care system, even now, to make an estimate of what was spent, by whom and how. Outsourcing, as we indicated earlier, has its advantages in taking the weight off the national exchequer but faced with a massive external shock, one of the huge difficulties is for the state as the "first responder" is to be able to establish how the system created actually works.

[69] https://ukhcablog.com/blog/homecare-in-the-time-of-coronavirus/
[70] https://www.nao.org.uk/report/adult-social-care-markets/

We commented in our earlier series of papers on the Covid-19 experience on how poor the available data was for many of the aspects of the pandemic in the beginning. No standard data series existed that covered the detail of events in the care sector. It was to the representative bodies like the UKHCA and UKCHA that one had to turn for information. It was only when the ONS was able at the end of April 2020 to come up with data on deaths for care homes in the UK that what had been happening was revealed.

3.2.2 The care home situation

For the two months of March and April 2020 in this information vacuum, the adult social care sector was largely left to fend for itself. It was revealed that, during this time, more than 12,526 care home residents (27.3 % of all care home deaths) were reported to have died in the first wave of Covid-19[71]. A month later, the total had risen to 19,394. It could now be shown that dementia and Alzheimer's disease was the most common main pre-existing condition found among care home deaths involving Covid-19. At this point in time, the number of deaths in care homes greatly exceeded the number in hospitals.

The emerging themes from the rapidly accumulating literature we referred to earlier were very much the same – poor preparedness, low resilience, lack of PPE, staff shortages and pressures, confused central messaging and an inability adequately to isolate residents. Maintaining infection control standards was also a problem. Guidelines were confused and constantly changing. Staffing issues were prominent with the numbers of care workers static or falling while the tasks to be performed for testing and isolation rose rapidly. Workers were increasingly either ill themselves or isolating in a family context. Levels of sick pay in the privatised market context added to the problems. Low-paid care staff on £8.50 an hour or those on zero hours contracts did not have the same sick leave entitlements as NHS employees. Many of them were faced with the choice between losing crucial income and carrying on working while symptomatic.

A key factor in the early days had been the transfer of untested patients to and from hospital during the infection peaks[72]. There was much reporting of the way care homes were to be used as a safety valve for the NHS to clear beds[73]. National guidance had been issued declaring that; as part of the national effort, the care sector had a vital role in accepting patients discharged from hospitals to create room for the treatment of acutely ill patients. This involved the 'easement of local authorities' duties under the Care Act, the suspension of complaints investigation by the LGO, and the discharge of Covid-19 patients from hospital to care homes, and the abandonment of CQC care home visits[74].

Testing was slow to get under way in the care home sector. The problems were that:

> *"Testing had taken place in 70% of care homes surveyed but only 36% of residents had been tested, of whom 16% were positive"* and that: *"Managers were unable to effectively implement isolation policies and reported that workforce and funding support did not always reach them. Guidance changed frequently and was conflicting and could not always be implemented, for example when personal protection equipment was extremely expensive and difficult to source" (Rajan, Comas-Herrera, & Mckee, 2020)*.

[71] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsinvolvingcovid19inthecaresectorenglandandwales/deathsoccurringupto1may2020andregisteredupto9may2020provisional

[72] https://news.sky.com/story/coronavirus-sacrificing-the-elderly-care-homes-asked-to-take-covid-19-patients-11969661

[73] https://www.theguardian.com/world/2020/jul/29/coronavirus-english-care-homes-policy-reckless-mps-say

[74] Care body 'disappointed' with CQC role during COVID-19 crisis" *Care Home Professional* May 26th,2020.

By the end of May and into early June. care homes were still widely unable to access sufficient funding, testing, PPE, workforce support and practical help with measures to support and isolate residents.

3.2.3 Domiciliary care struggling

The first data from domiciliary care showed that over the single month to 8th May, there were 3,161 deaths. in England (this was 1,990 deaths higher than the three-year average for the same time period) . By 19th June, the number of deaths of recipients of domiciliary care had doubled to 6,523 deaths, some 3,628 deaths higher than the three-year average (2,895 deaths). Both the visiting care workers and those employing them had been left out in the cold during the early rush to secure masks and gowns.

As independent commercial providers, they were largely expected to make their own arrangements to secure what they needed to look after those in their charge. It was not until June that some attempt at central and, later, free PPE was provided – but not without severe logistical problems for sourcing. Over Easter 2020, the Association of Directors of Adult Social Services wrote to the government about the appalling lack of PPE kit for both care homes and for domiciliary care providers.

There is much less research evidence on this aspect of care, but a plethora of media reports and stories appeared during the first wave telling of the heart-rending conditions faced by domiciliary care workers in coping with their clients' needs. Front-line workers found themselves in alarming situations where they had to do the best they could to obtain some form of PPE – canvassing nail bars, hairdressers and tanning salons to see if there were stocks available. Schools were drawn into action to make rudimentary kit for local use. Care homes and care staff generally were at the back of the queue for testing with limited numbers of test kits sent out only when outbreaks occurred – usually for residents and not for staff.

3.2.4 A sector without profile

The NHS crisis first arrived in the public consciousness when serious pressure on capacity limits, particularly in specialist areas like ICU arrived, and also when it reoccurred early in 2021[75]. The government moved to declare it as the joint responsibility of us all to '*Save the NHS'.* This was a part of the national public service that had been allowed to function dangerously close to capacity before Covid-19 arrived[76].(This issue appeared often across our 2020 series of papers on the pandemic[77]). The crisis in the NHS had the benefit of having a high popular profile, easily convertible into a coffee mug strapline about what was at stake.

In sharp contrast, when the pandemic arrived, adult social care, equally in crisis, received nothing like the same national attention – indeed the main drive for 'saving care homes' was more to save them from closing[78]. It says it all that, at the most critical time of the first wave, care home and domiciliary care providers found themselves for months without even the most rudimentary PPE[79] and even in April 2021, some still struggle with a lack of assured supply). It says a great deal that emergency funding support from government saw the NHS receiving £6.6bn with its debts written off while the care sector had to compete with the local authorities for a funding pot of £2.8bn. In January 2021, a further £269 million package was

[75] https://www.theguardian.com/society/2021/feb/28/uk-government-must-increase-number-of-nhs-beds-hospital-bosses-warn
[76] https://www.kingsfund.org.uk/blog/2019/12/five-reasons-why-nhs-winter-may-be-different
[77] https://www.peter-lloyd.co.uk/app/download/5811769967/Lloyd+and+Blakemore+Covid-19+Book+v27.pdf
[78] https://www.lancashiretelegraph.co.uk/news/6054514.care-home-battle/ or https://bosworthlibdems.org.uk/en/article/2010/0112743/sign-the-petition-to-save-local-care-homes
[79] https://www.bbc.co.uk/news/health-52145140 and https://www.nursingtimes.net/news/research-and-innovation/evidence-that-ppe-shortages-fuelled-covid-19-spread-in-care-homes-02-07-2020/

granted to boost social care staffing level and testing[80].The Spring 2021 budget saw the sector as a whole receive £341 million in extra funding[81]. It remains to be seen how far this will go to tackle even the damage of the past year let alone the accumulate funding issues of the last decade.

[80] Care Home Professional, 18th January 2021
[81] Care Home Professional, 18th March 2021

4.0 Conclusion

4.1 Emerging from the crisis

As we write this paper in May 2021, we are some 15 months beyond the beginning of the pandemic. Clearly the vaccination programme shows some light at the end of the tunnel: *"As each age group became eligible for vaccination, its share of all cases has fallen away. The share of cases among the over-80s has fallen by 80 per cent since vaccinations began" .*

The official Government 'Dashboard ' for Covid-19 on April 29 reported that we reached this position of optimism at the cost of 151,243 "Deaths with Covid-19 on the death certificate". The fragility of the ex-ante care sector remains. The vaccine has not 'immunised' the care sector (or ourselves for that matter – it has substantially reduced the chance of being seriously ill with Covid-19), nor has it overcome the systemic resource issues, overwork, trauma, and exhaustion for the NHS.

So, will the Chancellor and the Prime Minister agree on how to 'reform' the NHS, and will social care sector be recognised as joined-up component with healthcare? Something has to change, but what will be needed? As a devastating study reported in the journal *BMC Geriatrics* put it:

> *"Our findings show that healthcare and care homes are interdependent, and that these interdependencies are complex … Multiple previous studies have reported the need to engage care home organisations, managers and staff in changes to the design and configuration of care in the sector. The findings presented in this paper show the potentially serious ramifications of the failure to do so. A valuable finding was the way in which are homes are interdependent upon, and embedded within, their local communities. When formal healthcare and social care were slow to provide the necessary support to care homes, third sector organisations, schools, shops, manufacturers and hospices stepped in" .*

When will it be taken on board that the question of how we care for elderly, disabled and disadvantaged people in our society is not something that we can only get around to when we get the economy working well enough to create a sufficient surplus? This has waited for our attention for 30 years while the looked for surplus has proved ever-elusive. The real question is about the nature of the society we want for ourselves, our children, our parents and grandparents and it touches fundamentals. It is not just something that must wait for "trickle-down" economic benefits that never materialise. And we had better work it out that the problem is already, like climate change, a problem we know will get worse not better. We need to look closely at "*what we value"* in the here and now. It is a societal choice we have to make, not a system fix.

4.2 Facing up to the problem of an ageing population and its health needs

> *"In 1998, one in six of us was 65 or older. By 2018, it was one in five. By 2050, according to official projections, it will be one in four. Many of us will be able to live independently in our later years, perhaps with a little support, but some of us will need much more care: the numbers living with dementia are forecast to rise over the next 20 years from 850,000 now to 1.6 million" (New Start, 2021)*

This statement gives some idea of the huge challenge in front of us. Like the climate emergency it is an issue for the future that we already know is going to happen. It is not, like Covid-19, something that can

take us by surprise. The sheer costs arising from demographic ageing will be enormous especially when we bring pensions and the retirement age into the equation[82]. Health costs will rise in parallel with population ageing as people live longer. In 1951 the average life expectancy[83] for males was 66.4 years, and females 71.5 years. By 2011 it was 79 for males and 82.8 for females.

Only since November 2018 has the standard pension age of 65 been allowed to creep up[84] - at a glacial pace compared to the increase in longevity. We are behind the curve. From being something in the early 1900s to avoid people over 70 becoming impoverished, "*Recent reforms have tilted the system further in the direction of a universal flat-rate benefit, abandoning any social insurance des*ign" It is no surprise, then, that governments have turned to other sources of capital and revenue funding beyond that from the public purse.

Against this background there are still questions to be raised about justice and fairness even though the central issue is the overall funding. It is not possible to look the other way as these multiple challenges confront us. As we have just seen, the pandemic had the salutary effect of waking us up to what can happen. We need to move now to address the health and social care issues that have been known for decades and to use this to raise national awareness of both the short term and the long term issues we collectively confront.

We have to continue to bear in mind the big questions. However, *we are where we are*. The system we have in place, is one that cannot easily be swept away in the short term regardless of the enormous issues it faces. The immediate task is to fix what can be fixed but acknowledging that is far from a solution. Many of the practical possibilities have been set out for decades by those with specialist expertise of the field. The real issue has not been ideas but *political will.*

Taking up the same theme, the leading organisations in the care sector have stood up to call for what they describe as a *"1948 moment"*. Declaring that a sector "already on its knees" needs a plan, they call for one "that will enable a long-term future, the protection of citizens and a reduction of burdens on the NHS"(Clarke, 2021). Just facing up to the sheer scale and difficulty of what might be involved and confronting the electorate with the hard political choices involved would be a first step.

4.3 Starting a national conversation

4.3.1 Setting a national baseline

From the previous sections of the paper, we suggest that there emerge at least four key questions to be addressed. Three are system fixes and there is already some movement to address them. But the first question demands a national debate that, up to here, we have not found the opportunity to have. The question is:

- *What principles should we set as a nation for the minimum requirements of a morally just and fairly applied system for those who need assistance as problems arise in the process of ageing?*

[82] https://www.ifs.org.uk/bns/bn105.pdf

[83] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/articles/howhaslifeexpectancychangedovertime/2015-09-09

[84] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/310231/spa-timetable.pdf

This is a deeply political question. It would need much more than a White Paper and a legislative programme. A national debate would be needed on the basic priorities of our society for the 21st Century. This should sit alongside and be part of the debate dealing with the climate emergency. On both counts, we would need to be talking about a different kind of society from the one we have been living with over the last four decades.

Marianna Mazzucato, (*The Value of Everything, 2019*[85]) and Mark Carney (*Reith Lectures 2021*) have recently provided a place to start. We would need to be talking generally about *what we value* and understand better the difference between public value and private value. The accepted position in the UK in the post-Thatcher era has been an underlying market ideology privileging private value and the processes of financialisation - even for those public and welfare goods we consume in common. What we have just been looking at across the history of social care has been based on this ideology. As the record shows, whatever fiscal benefit and cost efficiency was associated with this, the system that arose out of it for health and social care was, by almost universal agreement, a deeply flawed one.

Events revealed its limitations. The financial crash and the decade that followed saw the public realm severely cut back under the austerity programme with significant and damaging implications for the most vulnerable in our society. Tragically, this was immediately followed by the pandemic – the greatest economic, social and health crisis for centuries. It was here that the vulnerabilities that had led us to forego the resilience we needed as a nation left us exposed.

4.3.2 Re-evaluating the marketisation and financialisation approach

In order to take on board properly the need to; *"enable a long-term future,(and) the protection of citizens",* it would be important to look at the present arrangements for depending dominantly on private sector interests to deliver a welfare service at arm's length. Clearly, there are some advantages to be gained from this - not least the savings in capital and revenue to the national public accounts and the sheer variety that a national "marketplace" for care provision can offer. However, the arrangement has had its drawbacks, not least in the conditions that austerity economics and the market approach generated for the 1.65 million people in the adult social care workforce.

The *market* for care, as we pointed out in Section 2, is not one that gets even close to the standard supply, demand and price model as perceived from neoclassical economic theory. Pricing structures, public and private, are a problem and there are issues about the shape, quality and spatial configuration of supply that emerges. Consumer knowledge and opportunities for switching are certainly not as in the private marketplace. Long-term care, once purchased, can lock the buyers (effectively renters) of residential care into a position where there at risk of not only losing virtually all their savings but a substantial share of the equity in their home. This cannot be right, particularly where the value of those assets disappears offshore through opaque structures of ownership. The absence of an upper threshold of assets at risk for care payments to independent providers exposes people to a severe penalty for being unlucky enough to have a dependent with dementia some other disabling disease. Dilnot found a solution that was by-passed a decade ago.

Capturing value for money in public procurement when purchased through a private contract brings in collateral effects from the logic of the market. For example, contract pricing requires particular output metrics set out as clear measurables. Measuring the value of a contract for care by bed availability plus "hotel" services or by "task and time" may be good for contract compliance but not for complex, hands-on

[85] https://www.penguin.co.uk/books/280/280466/the-value-of-everything/9780141980768.html

care delivery. Where unpriced externalities occur in the nature of the process, the true costs of care are under-estimated. For a patient-centred care process that demands the collaboration and integration, a market of competing providers has obvious limits. Once again, this is often not how things tend to happen on the ground. Adjustments ranging from applying staff goodwill to contract flexibilities and multi-provider agreements have been widely applied to make the system work. The system in place works, in fact, not so much by market design as by the application of fixes, added sub-structures, and one-off insertions of special payments from government. But this is not without some serious implications for those cared for, those providing the care and those who work at the front line delivering the care.

Marginality is a general descriptor that applies widely to the current market system of delivery. Too many people receive care constrained by tight local authority funding margins. Too many providers work and survive at the costs margin. Too many employees receive marginal wages that can keep them living in precarious circumstances. Whatever the advantages and disadvantages of engaging with private sector providers in a marketplace, this interacts profoundly with the *amount of resource available* to support the social care budget. With enough sustainable resource, the whole system - even its present form - would be easier to reform.

4.3.3 Fixing the system as it is

From the perspective of the recent government White Paper, the overarching questions of what moral, ethical and equity values should be set for adult social care are left in abeyance and the basic market model is accepted without comment. The government is setting out simply to fix the system in place. This being so, the following questions should be asked of any emerging policy:

- On the way toward a new kind of more resilient and sustainable post-pandemic system for the delivery of social care, how can the existing arrangements be better organised and regulated to meet the standards of *equity and fairness* we set as the long run goal?
- How should a system be designed to deliver the most effective and efficient outcomes in a coherent and integrated way – one that recognises and accounts for the *variety of social and spatial conditions* of people's lives?
- In financing the evolving system, what principles should apply to the *balance between the financial contributions made by the state and that made by the recipients of care and their family members* - respecting the core principles of equity and fairness?

A start was made in answering the first and second of these questions in the White Paper, but we still await government views on the third which is a critical one. The themes addressed range over: *"working together and supporting integration; stripping out needless bureaucracy; enhancing public confidence and accountability; and additional proposals to support public health, social care, and quality and safety"* (Kings Fund, 2021). The bulk of the document is dedicated to issues of policy governance. The Preface sets this out as follows:

> *"We are living through the greatest challenge our health and care system has ever faced. Yet even in crisis conditions, everyone working in our health and care system has continued to deliver excellence. Critically, collaboration across health and social care has accelerated at a pace showing what we can do when we work together, flexibly, adopting new technology focused on the needs of the patient, and set aside bureaucratic rules"*[86]

[86] https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version

What we have then, is essentially a “systems fix”, looking to re-engineer the existing arrangements to meet many of the various critiques that have emerged over time. The leitmotif is better accountability, integration and connectivity. There is a serious lack of ambition in a document pulled together in the middle of a pandemic. The big issues as we have raised them here are simply set aside. A real policy review would have needed more time and certainly more consultation and reflection.

A number of the issues addressed earlier in the paper are, however, covered. The issue of *accountability* is addressed in a number of places: at central government level, in the NHS, in relations with local government, and on the ground in a series of new structures. These are connected to the flagship innovation *Integrated Care Systems*. The ambition is to bring to the table providers, the voluntary sector, CCGs, the acute services and specialisms across the health and voluntary sector community. Consistent with past practice, the clear distinction between the providers of care (the set above) and the care funders is maintained. These accountability and integration fixes are of course welcome, but what is missing (and was also absent from the March 2021 Budget) is any sense of the *scale of the funding* that will be involved. It is hard to get excited about them until government thinking emerges on how and by how much it is all going to be funded.

Two other things we would highlight from our earlier perspectives as being particularly welcome is that the *geography of the system* is being given more sophisticated attention than is usual. While the attachment to the higher tier local authorities for commissioning is retained, it is now understood that most of what actually goes on in adult social care is “on-the-ground” and that the local context and the configuration of local institutions have a powerful role to play. A second highlight, not unconnected with the first is that *data systematisation* is on the new agenda. Writing throughout the pandemic as geographers with a sense of space and of space differentials, we have been far too often forced to run blind about critical things happening at levels of spatial aggregation below the county and the major city.

For the time being, the reform of health and social care under the current administration is a preliminary system fix in embryonic form. It is the matter of *finance* that will either change the game or not. For those under means tested care, those working at the margin to provide a service, those paying privately at rates that bite heavily into life savings and home equity and, particularly, those workers who have sacrificed so much in the last year, the statement needed from government is *how much and from where* they plan to bring to adult social care (and social care in general) the enormous additional resources needed to create a fair, sustainable system out of a welfare system that has fallen badly into disrepair.

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