THE NEXT MEETING WILL BE HELD ON

Monday 5th December 2011 2.00pm-5.00pm at
King’s College London
Room 1.70, Franklin-Wilkins Building, Stamford Street
London SE1 8WA

Care Arrangements:
Who Cares? Who Pays?

The recent reports of the Dilnot Commission and of the Law Commission on adult social care offer new financial and legal frameworks for the provision of residential care for older people. The present state of this service gives considerable cause for concern. How did we get here, and what might the future hold?

We have been lucky to be able to assemble an impressive panel of speakers:

Professor Pat Thane is an eminent social historian, Research Professor at King’s College London

Tim Spencer-Lane led the Law Commission’s review of adult social care law

Peter Westland was a Director of Social Services and subsequently Social Services Secretary to the Association of Metropolitan Authorities

Professor Jill Manthorpe of King’s College London and SWHN will chair the meeting

A background paper is attached.

Social workers, archivists, historians, students and any others interested in the history of social work are welcome

Please contact Janet Robinson at scwru@kcl.ac.uk by Friday 25th November 2011 if you plan to attend.

£10 donation welcomed on day; student concessions Attendance certificates on request
1. Cash and Care

1.1 Following publication of the Beveridge Report in 1942, the years immediately after the Second World War saw significant changes in the law relating to welfare (or social security) in the UK. The Family Allowance Act 1945 was implemented in 1946. It was followed by the National Insurance Act 1946, which brought together the state contributory insurance schemes such as Sickness Benefit, Retirement Pensions and Industrial Injury Benefit administered by the Ministry of National Insurance. The National Assistance Act 1948 separated the cash and care functions of the Poor Law. Those not entitled to contributory benefits or whose benefits were deemed to be inadequate could receive a means tested allowance, known as National Assistance, administered by the National Assistance Board (a Central Government Agency) while Care remained the responsibility of Local Authorities (LAs) under Part III of the Act.\(^1\) These provisions were implemented, together with the NHS Act 1946 and the Children Act 1948, on 5th July 1948. The functions of social security benefits and of care were then distinct. People who needed care were to be provided with relevant services, and not with cash to purchase their care.

1.2 The introduction of new benefits specifically related to disability, e.g. attendance allowance (1971), invalid care allowance (1975), mobility allowance (1976) and disability living allowance (1992), changed the picture. These benefits were intended to meet or contribute towards the extra costs of living with a disability, and they therefore blurred the distinction between the functions of cash and care. The state at national level was now providing cash for the purchase of care. Then, in 1996, the Community Care (Direct Payments) Act gave local social services authorities the power to give service users cash with which to buy services instead of directly providing or commissioning services for the user.\(^2\) Thus the state at both national and local level can now provide cash with which to buy care, and the 1948 separation of cash and care between the national and the local state has now been more or less replaced by a division between the public sector, which provides the

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\(^1\) Whereas the NHS Act 1946 had set up a health service free at the point of use (subsequently eroded by the introduction of charges for teeth, spectacles and prescriptions), residential care was to be charged for with a means test. Confusingly, both free health treatment and chargeable social care were introduced to avoid the stigma of charity and to break the link between public provision and indigence.

\(^2\) Direct payments are to be distinguished from personal budgets, where the service user is given a notional personal budget which is held and spent by the L.A. Both direct payments and personal budgets may be varied at the discretion of the L.A to reflect either the beneficiary’s changing needs or the L.A’s changing financial circumstances. Compared with social security benefits, they have the advantages and disadvantages of greater flexibility. The King’s Fund has, however, suggested that Attendance Allowance should be integrated into L.A personal budgets.
money both for basic living costs and for the purchase of care, and the independent sector, which largely provides the care.  

2. Care for whom?

In the 1950’s, normal daily life was more arduous than it is now, and the physical limitations which at that time more often accompanied ageing were more likely to make it impracticable for people to look after themselves at home. By the early 1970’s, as a result of technological advances, improvements in housing, better domiciliary services and the development of sheltered housing, many of the circumstances which had in the past led to admission to residential care no longer pertained. It became possible to speculate that residential care might be replaced by sheltered housing with additional communal facilities, supported by individualized community care services. What such speculation ignored was the increase in the number of older people suffering from various kinds of mental confusion, probably resulting principally from increased longevity, and the NHS’s progressive withdrawal from continuing care. There has therefore been a significant change in the nature of the residential care population.

3. Who pays: central or local government? And who provides: local government or the independent sector?

3.1 In 1966 the NAB was replaced by the Supplementary Benefits Commission (SBC), as part of an attempt to make non-contributory means-tested benefits more of a right. These benefits were no longer to be “applied for” but to be “claimed”. There was to be more entitlement and less discretion. Some discretion was, however, essential, and its exercise became a focus of contention as a new profession of welfare rights advisers sought to establish new rights based on a “case

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3 But most LA money still passes straight from the LA to the provider without passing through the hands of the service user.

4 The Supplementary Benefits Commission was set up under the Ministry of Social Security Act 1966 as the body to administer the new system of social security entitlements, in conjunction with the new Ministry of Social Security. Together with this Ministry it inherited the functions of the former Ministry of Pensions and National Insurance and the National Assistance Board. The Commission was responsible for determining the rights of applicants to pensions and allowances and the amounts payable and for advising the government on social security benefits policy. Its powers and responsibilities were consolidated in the Supplementary Benefits Act 1976. In 1980 the Commission was abolished. Its advisory role passed to the new Social Security Advisory Committee and its executive functions were taken over by the Department of Health and Social Security (DHSS). The DHSS had itself been established in 1968, merging the former Ministries of Health and of Social Security. Its cabinet minister (initially Richard Crossman) was designated Secretary of State for Social Services. The title reflected the assumption of a co-ordinating role in relation to the broad range of social services which had previously been exercised with considerable difficulty by a succession of “overlords” (including Douglas Houghton, Michael Stewart and Barbara Castle), who usually did not carry any departmental responsibility. Health and Social Security continued to function very much as two separate departments, each headed by a Permanent Secretary. The Department also had an Office of the Secretary of State for Social Services to handle the co-ordinating responsibilities. In 1970, when an issue arose as to whether the DHSS or the Home Office should assume responsibility for the LA personal social services, Harold Wilson observed to Crossman that he thought they had merged the wrong two departments.
"law" of officers’ discretionary decisions. An important development of this kind was the extension in 1980 of SB board and lodging payments to take in payments for residential care. This had several consequences.

3.1.1 People were moving into residential care on the basis of a test of means without an assessment of their need for care.

3.1.2 There were now two sources of public funding of residential placements: LAs and the SBC.

3.1.3 Private, as well as local authority and voluntary, homes could now receive public funding (from the SBC but not yet from LAs).

3.1.4 Because local authority homes became the only establishments whose residents (if they had insufficient means) were not eligible for SB funding, the effect was to drive local authorities out of direct provision (via an intermediate stage of provision by “arms-length” companies).

4. Curbing the expansion

As discretionary decisions were consolidated into rights, SB expenditure grew uncontrollably, and this in turn led to two further developments.

i) Supplementary Benefit was abolished in 1988 and replaced principally by Income Support, which was means-tested but entitlement-based and without flexibility to respond to exceptional needs and circumstances. Discretionary power to respond to needs and circumstances for which Income Support could not provide was vested in the Social Fund, which was, however, subject to tight budgetary control. When money was available, it dispensed both grants and loans.

ii) Social security funding of residential care ceased, and responsibility was passed back to the LAs who had been accidentally relieved of it, where it could more readily be controlled.

5 The SBC’s funding of residential care at a time of increasing pressure on local authority expenditure, which arose from a growing older population and from the NHS’s increasing concentration on medical treatment and progressive withdrawal from illness-associated care, enabled that sector to grow, mainly in the private sector, more rapidly than Government might have allowed local authorities to expand it. Local authorities were able to make considerable savings on their residential care budgets and to redirect this money into domiciliary services and into looking after mentally-ill and learning-disabled people, from whose care the NHS was withdrawing (from long-term care in the case of mental illness and from all residential provision in the case of learning disability). Although machinery was put in place to transfer funding from the NHS to LAs to accompany patients discharged from long-stay hospitals, there was no similar funding arrangement to help LAs provide for those who were no longer being admitted.

6 Loans could be, and were, refused on the grounds that the applicant could not afford to repay them, but they became an important part of the Social Fund’s work as they made its budget go further, with repayments financing further loans. The loan system meant in effect that the state was limiting public expenditure by setting up a system through which its poorest citizens lent to one another. This was of course better than resort to loan sharks.

7 There was a subsequent transfer of funds from central government to local authorities.
Thus, the upshot of the SBC’s involvement was that payment reverted to the LAs, but provision largely moved into the independent sector, a move facilitated by the NHS and Community Care Act of 1990, implemented in 1991, which for the first time empowered LAs to finance residential care in the private as well as the voluntary sector. The Act also provided that residents’ own contributions to the cost of their care should be paid direct to the provider and not, as before, collected by the local authority, a change which altered the nature of this triangular relationship.8

5. Who cares who pays?

5.1 Through the 1950s and 60s, the issue of who pays presented few problems. Few residents had owned their own homes or amassed sufficient savings to require them to pay for their own care, so that, although indigence was no longer a condition of admission, the state was still meeting the great bulk of the cost. A few better-off older people lived in LA homes, paying the full cost of their care, but most of them still tended, as they had in the past, to go into nursing homes (not then eligible for public funding) or, if less unwell, into small private hotels, although some did use private older persons’ homes.9

5.2 But this situation changed. Poverty came to afflict the older less and families with children more. The sale of council houses and the promotion of a property-owning democracy produced more older owner-occupiers and fewer older tenants. For many adult sons and daughters, the chance of inheriting a parent’s home came to depend on whether the parent needed residential care. The feeling of unfairness that this has generated has been exacerbated by the lack of public understanding of, and a fortiori of support for, the different financing arrangements for NHS and social care services, and by the progressive withdrawal of the NHS from the provision of illness-associated care. There was a common erroneous belief that a full National Insurance contribution record would carry an entitlement to free residential care in old age. Many people now care very much who pays. Dissatisfaction has reached such a point that both the current and the previous governments have tacitly accepted an obligation to safeguard sons’ and daughters’ hopes of inheritance, although no actual “right to inherit” has of course been proposed.

6. Dilnot

The Dilnot Commission was set up to propose a way out of this problem. Its recommendations include:

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8 The two changes mentioned here are in the 1990 Act itself. Most of the other changes associated with this Act result from ministerial guidance and directions. Under the Local Authority Social Services Act 1970, local social services authorities had been required merely to act under the general guidance of the Secretary of State. The 1990 Act gave the Secretary of State a new power to direct them. This reflected the way in which relations between central and local government had changed during those twenty years.

9 Peter Townsend’s The Last Refuge (Routledge, 1964) records that in 1960, of a total number of about 111,000 places, 74,000 (two thirds) were provided by LAs, half of them in former Public Assistance buildings. Of the remaining one third (37,000), only 11,600 were in the private sector. They were in much smaller establishments, averaging about ten places, compared with 120 in former Public Assistance homes, 35 in other LA homes and 30 in voluntary homes. (I have rounded Townsend’s figures.)
Capping service users’ lifetime contributions to the cost of their care at £25,000 to £50,000 (with £35,000 as their preferred amount);

Raising the threshold below which service users’ means are not assessed from around £23,000 to £100,000;

People in residential care should pay £7,000 to £10,000 a year to cover general living expenses;

People whose need for care arises before they are 40 should not have to contribute towards the cost of their care (as distinct from their general living expenses).

The estimated cost of the proposals to the public purse is £1.7 billion, rising to £3.6 billion by 2025/26. The proposals have been widely welcomed, by bodies as diverse as The Joseph Rowntree Foundation, The King’s Fund and The Association of British Insurers. Nevertheless the additional cost of forgoing some of the income currently received from service users seems a substantial amount to add, particularly at a time of public expenditure reductions, to the public cost of a service which is already underfunded. Recouping these extra costs to the public purse through a change to inheritance tax would mean that any increase in public expenditure could be devoted to improving the care provided.

7. Care arrangements – national and local

7.1 Adult Social Care - the Law Commission’s Report

The report proposes a legal framework consisting of a primary statute, regulations and a code of practice. This framework would give primacy to individual well-being, with a presumption that persons are the best judges of their own well-being. It would create a duty to assess need for social care services, require LAs to have a scheme for setting criteria for eligibility for services, and give them a duty to arrange or provide services to meet all eligible needs. This duty would apply to each individual case and would be enforceable through judicial review. The Report’s Summary states:

“The statute would require the Secretary of State and Welsh Ministers to make regulations prescribing the eligibility framework for the provision of community care services, which local authorities would have to use to set their eligibility criteria. The code of practice would specify how local authorities should set their eligibility criteria, including the needs the authority must, at a minimum, provide services to meet. However, our scheme would also allow the Governments to set eligibility criteria at a national level in England or in Wales, if either Government wished to do so.”

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10 Residential care has generally been viewed as expensive, compared to domiciliary support, despite the obvious relative inefficiency of the latter in increased staff travel time and costs and concomitant loss of productive working time. Residential care is expensive to adult social services because the great bulk of its public costs fall on them, whereas the total public costs of maintaining dependent people at home are more widely spread, and are not often quantified.
There seems to be a desire here to tilt more towards need the scales on which need is weighed against cost. Taken together with the Dilnot recommendations, there is a strong suggestion of a curbing of local discretion, and it may be that consideration of these two documents will provide a forum in which the idea of a “National Care Service” will be further discussed.

7.2 Adult Social Care – the place of social work
The Law Commission’s Summary also makes a distinction between primary and secondary services.

“In our scheme there would be two levels at which adult social care services could be provided. The first is a universal level, with the provision of universal services to the wider community to help prevent or delay the need for more targeted social care interventions. Here local authorities would have a broader role to ensure the provision of information, advice and assistance to people who have not had or do not want an assessment, or who are not eligible for services. Authorities would also have a responsibility to stimulate the development of sufficient types of services and support in the local market. The second level would be targeted social care services, provided following a community care assessment.

“The new statute would set out a single, clear duty to assess a person. As under the existing law, there would be a low qualifying threshold for an assessment which is triggered where it appears to a local authority that a person may have needs that could be met by community care services.”

7.4 Where would social work services be placed within this schema? Much has changed since 1973, when the Central Council for Education and Training in Social Work (CCETSW) published a report entitled “Residential Care is Social Work”. In 1977, CCETSW introduced a new qualification, the Certificate in Social Service (CSS), in parallel with the Certificate of Qualification in Social Work (CQSW) which it had introduced in 1971. With some exceptions, primarily in children’s services, the CSS became the preferred qualification for work in residential services. When, in 1989, the Diploma in Social Work was brought in to replace both CSS and CQSW, this did not lead to any sustained attempt to reassert the relevance of social work education to residential practice. In children’s services there was a strong lobby in favour of a continental European model of a profession (Specialist Educator in France, Social Pedagogue in Germany), appropriate for but not confined to residential work practice, separate from social casework but part of a broader concept of social work. In the care of older people, where the commonest qualification for senior staff had been a nursing one (SRN or SEN), NVQs became the expectation. Many “external” managers (assistant directors and principal officers) of residential care in LAs had been qualified in social work, but this pattern was not replicated in the private agencies which took over the bulk of residential care provision in the 1990s. On top of these changes came the introduction of schemes of care management and purchaser-provider separation associated with but not mentioned in the NHS and Community Care Act 1990. Purchaser-provider

11 Note the assumption that universal services are provided within a “market”.
the social-work role of assessing need for services should be separated from the provision of social work as a service in its own right. It is difficult if not impossible to reconcile this organizational arrangement with a view of social casework as structured and purposeful conversation which aims over a period of time to clarify needs and problems, to identify strengths and to support change, and in which assessment and service are inseparable. The upshot has been that social work in adult social care has been pretty much confined to assessment of need for community care services and to adult protection work.\textsuperscript{12}

7.5 The Law Commission’s proposed scheme of services at two levels, with an assessment gateway guarding the second level, could easily be read as assuming the continuation of this limited function for social work. It is important, therefore, to note that the Commission includes in its definition of “community care services”, that is, services lying beyond the gateway, “advice, social work, counselling and advocacy services”. This definition clearly establishes that social work should be available as a continuing service beyond the assessment process. Furthermore, advice, counselling and advocacy are services which are often found in more universal settings, accessible without recourse to a community care assessment. It is reasonable, therefore, to assume that social work, too, should (or at least could) in the Commission’s scheme be available as a contribution to universal services alongside “information, advice and assistance”, provided by social workers who could, as and when desirable, undertake or contribute to community care assessments, and provide any further social work help that the assessment showed to be needed, thus making possible desirable continuity of relationships.

8. The ideas behind the care arrangements

8.1 Ideas and values underlying the provision of public residential services in the 1950s, 60s and 70s suggested that efficiency, effectiveness and propriety in their delivery should be achieved through:

- Local democratic control under the guidance of central government;
- Audit of expenditure by finance professionals and inspection of services by experienced members of the relevant professions;
- Integrated planning, management and delivery of services;
- Developing professional knowledge and skill for use in the service of the state.

8.2 The fitness for purpose of these values and arrangements came under question in the 1980s, and the introduction of “community care reforms” in the 1990s meant that these more traditional values had to coexist with, and to some extent were replaced by, a rather different set of beliefs:

- That costs are best controlled through the operation of markets;

\textsuperscript{12} The Law Commission’s report devotes a substantial chapter to adult protection.
• That, if those in need of services cannot fulfill the role of customers in a market, and can only be “consumers” or “users” (because they lack the money to buy the services), then surrogate purchasers should be invented for them, so that a market can be set up (even if the purchasers and providers in this quasi-market are two parts of a previously integrated LA department, that is, an “internal market”);

• That the private sector is more efficient than the public sector, and that outsourcing the provision of services to the private sector is even better than setting up an internal market within the public sector;

• That direct provision of public services is tainted by “provider self-interest”. In other words, that public officials run their organizations’ affairs to suit themselves rather than those whose needs they are employed to meet;

• That the inspection and regulation of independent sector services by democratically-accountable public sector organizations providing similar services is unacceptable, because it involves a conflict of interest.

• That the regulation of a profession should be undertaken by people skilled in regulating, rather than in the practice of the profession in question, and, similarly, that the inspection of services should be undertaken by people with generic inspection skills rather than the skills required to provide the service.

8.2 A survey of 230 social workers conducted by BASW in 2011\textsuperscript{13} found that:

• 81% had seen instances of abuse in care homes;

• More than half had seen ‘extreme abuse’;

• 70% thought that residential care was not fit for purpose:

• Half had come across homes they thought should be closed;

• More than 65% had reported a care home for failings;

• More than half said they would not place one of their own relatives in a care home.

It is time to look again at the arrangements for providing, paying for and inspecting residential care and at the principles on which these arrangements should be based, and at how best to translate a statutory duty to give primacy to individual well-being into its actual achievement.

Keith Bilton, 08.10.11

\textsuperscript{13} Professional Social Work, September 2011, p.9.