



COMMENT

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A relational (re)view of the UK's social care crisis

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ABSTRACT It has become commonplace to say that there is a crisis in adult social care in the United Kingdom. This comment reflects on empirical and conceptual work on care, and feminist perspectives on re-valuing care, to make the case for a fundamental re-appraisal of how we resource and regulate adult social care. The problems generated by the uneven implementation of contemporary legal frameworks and the chronic underfunding of social care are explored, to demonstrate how regulatory, governmental and policy choices shape the everyday experience of delivering and receiving formal care services. Once these relational connections between regulation and everyday life are exposed, the need for a different, fairer and more just approach to care regulation becomes clear.

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Introduction

We are often told that, in the United Kingdom, there is a “crisis” in adult social care (Ferguson and Lavalette, 2013), that the social care system is at “breaking point” (Butler, 2017), and that a “dementia time bomb”, which will cripple our health and social care services, is the inevitable consequence of increasing longevity (Cooper, 2014; Maguire, 2017). The challenges of an ageing population, and the prospect of increased care needs and expenditure are not limited to the United Kingdom: it is estimated that over two thirds of those with dementia live in low and middle income countries, and that the direct costs of dementia care alone will reach over a trillion US\$ by 2018 (ADI, 2017). As global populations enjoy greater longevity, the issue of how to provide care for older people has become a pressing social, legal and political issue. Most commentators agree that *something* needs to be done to tackle the social, economic and political challenges posed by increasing needs for social care. Less attention, however, has been paid to the socio-legal dimensions of this issue in the United Kingdom and beyond. The immediate causes of the contemporary care crisis in the United Kingdom are often attributed to a lack of funding for social care, an issue exacerbated by the austerity politics of the Conservative led UK Governments from 2010 to 2017. While underfunding is certainly a problem for social care, and has led to increasing levels of unmet care need, it is not the sole cause of the current social care “crisis”. As a result, simply spending more money on social care in the current system and within the current regulatory framework will not suffice. Instead, solving the crisis in adult social care requires innovative solutions that take account of the complex, intersecting causes of the current systemic crisis.

The causes of unmet care need, beyond “underfunding” include: the relational reality of care, and the ways that policy choices interlock with legal and social norms to shape personal experiences of and responses to care needs; the privatized nature of the social care system in England and Wales which both creates and iterates unfairness in the system; and complicated regulatory frameworks for care providers which generate complexity and unaccountability in care provision and contribute to the abuse and neglect of care recipients. I will deal with each of these issues in turn.

Relationality and social care

At least since Margaret Thatcher’s famous comment in 1987 that there is “no such thing as society” (<http://www.margarethatcher.org/document/106689>), the individual has been ascendant in English law and policy. In the context of social care, this translates into individuals with care needs, individuals who provide care for their friends and family members, and individuals who purchase care services either for themselves or for others. Yet closer interrogation of statistics relating to care needs, and care provision at population levels demonstrate the relationality of care giving and receiving in contemporary society. Relationality, as a feminist concept, allows us to see the complex and interconnected nature of different regulatory regimes that impact on care (Harding, 2017). Nedelsky (2011) argued that we need to be attentive to the nested relationalities that shape everyday life; the ways that intimate and interpersonal relationships are shaped by social norms, economic relationships, and legal contexts. In the context of care, using a relational lens means that we can see how governmental and policy choices to restrict access to state funded care through means testing generate both a mixed economy in state and privately funded care provision, and reprivatisation of responsibility for care on to family members.

Office of National Statistics (ONS) figures show that over 10 million people had social care needs and were limited in the activities of daily life because of a health problem or disability in England and Wales in 2011 (ONS, 2013a). Only a small

proportion of those who have care needs received services from a local authority in 2014/2015: 890,000 people received long term support; 209,000 received short term support to maximise independence; and 57% of the 1,811,000 new requests for support from local authorities received no support (NHS Digital, 2016). Most people who need care live in the community, and the residential care home population has remained relatively stable over recent years at around 300,000 (ONS, 2014). Approximately 10.3% of the population, 5.8 million people, provided unpaid care to a friend or relative in England and Wales 2011. The majority of informal carers in England and Wales (around 3.7 million) provide between 1–19 hours of care per week, with 775,000 people providing between 20 and 49 hours of care per week, and 1.4 million people providing over 50 hours per week of unpaid care (White, 2013). The absolute number of carers increased by 600,000 between the 2001 and 2011 census dates, and the proportion of the population providing 20–49 hours per week and over 50 hours of care per week each grew by 0.3 per cent. Census data also shows that levels of unpaid caregiving vary significantly by geographical area, gender, age, and ethnicity. Carers are more likely to be older (between age 50–64 is the largest group), women, living in rural or northern areas, and of a minority ethnic group (White, 2013; Harding, 2017)

These statistics relating to care needs and informal care giving offer an insight into the interconnecting strands that constitute the relationality of care. Rather than understanding social care as primarily a public-sector funding problem, we need to be attentive to ways that changing social and economic norms have contributed to the generation of this “crisis” in social care. Whilst the numbers of people requiring help with the activities of daily living, and the proportion of those who have care needs in society has increased and will increase as a result of our ageing population, care needs, care work and care provision are not new phenomena. Caring is vital socially reproductive labour (Stewart, 2017), the economic and social subsidy from which has, historically, been significantly under-valued and under recognised (Hoskyns and Rai, 2007). As greater proportions of women have entered the labour market of the last 40 years (ONS, 2013b), women have been less available to undertake unpaid, informal, caring labour within the home. The gap between employment rates for women and men, which begins at age 22 and narrows after around age 40 (presumably accounting for childcare labour), widens again at age 50, which corresponds with the age group most likely to provide informal care and support to an adult. Viewing care through a relational lens allows us to see how policy choices, regulatory frameworks, and social norms interact to create the terrain in, on and through which care takes place.

Privatization, unfairness and funding social care

One of the major contributing factors in the current social care crisis relates to the predominantly private nature of the social care marketplace. Since the NHS and Community Care Act 1990, the social care system has been progressively opened up to market forces, ostensibly to increase choice, and introduce competition to reduce costs. The effects of this marketisation of social care have been to move social care provision from a public service provided by local authorities, to a “public services industry” which serves the profit-driven motives of private capital (Gosling, 2008/2011). In the 1980s, 90% of care services commissioned by local authorities were provided by the public sector; in the 2010s, the vast majority of such services are now provided by private enterprise (Ferguson and Lavalette, 2013).

Some companies involved in the private provision of public services make large profits but there have also been recent reports

of rising numbers of care homes declaring insolvency (Plimmer, 2016). The failure of Southern Cross Healthcare in 2011 at the point when they ran 750 care homes, accounting for around a tenth of the care home population provides a recent example of the problems associated with caring for profit. The demise of Southern Cross has been attributed to a failed business model, which sought to generate profit out of the property interests of care home provision. The consequences of private equity asset-stripping of care providers have been detailed in depth elsewhere (Scourfield, 2012). Quality issues can also contribute to the failure of care providers. Perhaps the most high-profile of these was the failure of Castlebeck, the learning disability care provider responsible for the Winterbourne View abuse scandal (CQC, 2014).

Failures of care providers are now regulated through the Care Act 2014, which gave the Care Quality Commission a statutory responsibility for market oversight of difficult-to-replace providers. These market oversight provisions are backed up by a duty on local authorities to meet the needs of the adults who were receiving care from a failed provider if that provider were to fail. This new regulatory regime may well be put to the test as more care providers leave the marketplace due to contemporary financial strains associated with increased staffing costs, recruitment and retention challenges associated with Brexit, and squeezed profit margins (CQC, 2016).

Increased staffing costs for the social care sector, as a result of the “National Living Wage”, have been estimated to cost the sector up to £2.6 billion each year by 2020 (Gardiner, 2016). There are also challenges relating to pay and conditions for care workers. According to the Communities and Local Government Committee (2017b), nearly half of care workers leave within a year of starting work, significant proportions (49%) of the social care workforce are on insecure “zero hours” contracts, and between 160,000 and 220,000 workers are not paid the minimum wage. At present, 7% of the care workforce, around 92,000 workers, are from elsewhere in the EU. If the Brexit process makes it more difficult for care providers to recruit and retain staff, then care quality is also likely to suffer, as well as profit margins.

The financial context of social care that has emerged as a consequence of the privatisation of the sector does not only impact on care workers (Hayes, 2017). Local authorities saw cuts to their budgets cut in real terms by 37% from 2010–2017 (CLGC, 2017a). Social care expenditure has borne a significant proportion of those cuts over that period, alongside dealing with increasing costs relating to increasing demand as a consequence of the ageing population; minimum wage increases; changes to the Deprivation of Liberty Safeguards following the Supreme Court decision in *Cheshire West* (2014 UKSC 19); and the implementation of the Care Act 2014 which introduced new rights for adults with care needs and informal carers. The combined effects of these cost pressures have meant that some local authorities have cut the amount they will pay care providers for care. As a consequence, care providers receive less than it costs them to provide the care, and self-funders are asked to pay more for care services. Underpayment by local authorities means that “some councils pay £2.24 an hour for residential care” and that “96% of people paying for their own care pay on average 43% more than state funded residents in the same home” (CLGC, 2017b: 3). In other words, care providers routinely rely on self-funders to cross subsidise the care provided to local authority funded service users.

The current approach to funding social care, particularly for older people with dementia, is perhaps the most unfair system possible. Not only are people unable to predict their future care needs and to plan for them, or pool risk through insurance products (Commission on Funding Care and Support, 2011), but

those who do develop high care needs in older age (such as people living with dementia) are penalised twice. They must pay for their own care until their capital reaches the threshold for local authority support, and whilst doing so they also subsidise the care provided to state-funded recipients. The gap between local authority fee levels and the costs of care also often means that if a self-funding care home resident reaches the asset threshold for state contributions towards their costs, their family may be asked to provide a “third party top up” fee, to meet the additional cost of care in their preferred accommodation,¹ or risk being moved into a cheaper care home. Third party top-up fees can also be required if a local authority funded resident chooses a placement in a care home that charges fees above the standard local authority rate. Top-up fees are a complex and relatively poorly regulated practice, the consequence of which is that relatives of the poorest care home residents may be required to subsidise the costs their care (Passingham *et al.*, 2013).

Regulatory complexity in social care

The Care Act 2014 transformed the regulation of social care in England, consolidating a piecemeal patchwork of regulation that had built up since the National Assistance Act 1948. Yet even following this new legislative model, there exists a great deal of regulatory complexity within the system. The legal framework surrounding social care is a clear example of decentred regulation (Harding, 2017). Decentred regulatory systems are marked by complexity, fragmentation, interdependency and a great deal of permeability between public and private domains (Black, 2002). In a fragmented regulatory system, it is assumed that “no single actor has all the knowledge required to solve complex, diverse and dynamic problems, and no single actor has the overview necessary to employ all the instruments needed to make regulation effective” (Black, 2002: 5). Regulatory complexity and fragmentation contributes to the care crisis in three key areas: through the difficulties people with care needs and their family carers experience in navigating the system (Peel and Harding, 2014); through the uneven applicability of human rights laws and norms; and through the lack of robust frameworks for gaining redress for those harmed by poor care.

The complexities of navigating the social care system stem from the existence of multiple private providers of different care services within the private social care marketplace. The stratified nature of provision within the system that has developed in response to governmental nudges around choice and competition mean that it is very difficult, especially for those who fund their own care (that is, the vast majority of older people and people with dementia), to navigate the system without professional help and support (Peel and Harding, 2014).

The private nature of care provision has also generated problems and complexities in relation to the applicability of human rights laws to care providers. Whereas healthcare in the NHS was always considered to be covered by the provisions of the Human Rights Act 1998 (HRA), the position of social care has not been as straightforward. Of particular importance in the context of social care are Article 8 rights to respect for private life, family, home and correspondence, rights under Article 3 to be free from torture and inhumane or degrading treatment, and rights to liberty and security of the person under Article 5 (Harding, 2017). Initially, privately owned and operated care homes were held to fall outside the scope of the HRA (*YL v Birmingham City Council and Others* [2007] UKHL 27). In 2008, the scope of the “functions of a public nature” was expanded to include those placed in private care homes by Local Authorities under the National Assistance Act 1948 (Pannick, 2009). Even this did not, however, ensure that all health and social care

providers were covered by the HRA, because domiciliary care continued to be excluded at that time, as did privately funded care (EHRC, 2011). The gap was subsequently further reduced by the Care Act 2014 (s. 73) to cover all care or support from a registered provider that has been arranged or funded by a local authority. Only those who arrange and fund their own care are now excluded from human rights protections (Clough and Brazier, 2014), but this may still include a large number of care recipients. The problem with such uneven application of universal standards is that there could, for example, be a care provider who infringes all of their service users' privacy rights, but only those whose care was funded or arranged by Local Authorities would have a claim under the HRA.

The differential treatment of different groups of care recipients depending on who arranges or funds their care is also an issue within the system for resolving social care complaints. Care recipients who arrange and fund their own care have fewer routes to redress if they experience a failure of care than those whose care is arranged and/or funded by the local authority (Harding, 2017). The latter can complain to both the service provider or the local authority; the former only to the service provider. The Local Government Ombudsman (LGO) has the authority to act as an independent adjudicator on all adult social care complaints, yet only 11% (319) of the adult social care complaints the LGO received in 2015 related to privately funded care. Given that it is estimated that around 45% of care home places and at least 20% of domiciliary care are self-funded (OPM, 2013) it is likely that this low rate of referral to the LGO is connected to a lack of public awareness of the ombudsman (Harding, 2017).

Regulatory complexity, uneven application of protective human rights frameworks to care recipients, and low awareness of independent complaints adjudicators all contribute to the crisis in adult social care. If care providers are unaccountable for their failures (for example, if complaints are left unaddressed and unresolved), then valuable opportunities for care providers to learn from their mistakes are lost. In addition, care recipients and their family carers may feel unable to trust social care providers to do a good job with the consequence that a greater burden of care falls on family members (Harding, 2017).

Solving the social care crisis

The causes of the current crisis in adult social care are not simply a result of the chronic underfunding of care. Rather, the problems of adult social care are the product of a number of complex and interconnected social, regulatory, and policy issues. Solving the social care crisis will require more than additional funding. Using a relational lens (Harding, 2017) we can see that policy choices (for example, to underfund and privatise social care), social norms (which for example, mean that privatised care responsibilities fall disproportionately on women), and regulatory systems (for example, that make navigating social care provision difficult, that unevenly respect the rights of care recipients and their families, and that facilitate low wage, insecure employment for care workers) all interact to produce the contemporary social care crisis.

The problems in social care are well known. There is already a wealth of academic, third sector and government literature that sets out the problem in great detail. Given the political uncertainty following the Brexit referendum outcome in June 2016, and the hung parliament result in the June 2017 UK General Election, there is a danger that momentum will be lost in the quest to solve the problems in adult social care. Governmental attention is currently focused almost entirely on the process of negotiating Britain's exit from the EU, leaving little regulatory space for innovative solutions to the social care challenge, despite

promised reform. It is unlikely that any of the manifesto commitments on care from the main political parties will be implemented by the current Parliament, given the lack of political consensus on these approaches. Contemporary political uncertainty could, however, provide unique opportunities for collaborative solutions, generated on the basis of consensus politics rather than partisan concerns. If these opportunities are seized, they could provide a foundation for the future of adult social care, that draws on a re-valued understanding of the place of care in society (Harding *et al.*, 2017).

Taking a relational view of the challenges posed by funding and regulating adult social care would provide space for the development of novel solutions to the care crisis. A relational approach requires us to keep in mind the ways that individual choices are shaped by interpersonal context, social norms and regulatory systems. Remaining attentive to this complex relationality whilst seeking to reform the regulatory model for care services will undoubtedly bring an added layer of complexity to the question of social care reform. Yet in doing so, it will allow the formulation of solutions that do not rely on assumptions about the privatised, neoliberal, individual socio-legal subject.

Current thinking about how to solve the "care crisis" tends to revolve around how to pay for the current system of privatised responsibility. A relational view forces us to think differently about the questions at the heart of the care crisis. Rather than asking should individuals who need care pay from their wealth or their income, it forces us to ask the more foundational questions about whose responsibility it is to care. My answer is that care is a social, not individual, responsibility. Care is no longer, and nor should it be, solely the duty of women within the privatised family, as a result of changing gendered patterns of employment. Nor should it be a low status, low pay, precarious form of paid employment. Care is socially essential; without it the rest of our economic system would collapse. As a result, the foundational necessity and relational reality of care must be given due attention in political discourse and regulatory responses to the current systemic care crisis.

Note

- 1 Care Act 2014, s. 30, and the Care and Support and After-care (Choice of Accommodation) Regulations 2014/2670, regulation 5.

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Additional information

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