Spotlight on Pensions
PRESENTS
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Tackling the care conundrum – time for some big thinking

The thorny issue of providing social care for those in need has been a problem for generations. Although the needs could arise at any time for any person, the demographic group overall most likely to require help is the elderly.

In past times when extended families of multiple generations lived together, the family unit collectively provided care for members in need. With the move to smaller family units, often geographically separated, the availability of that option has decreased just as life expectancy – and therefore the statistical likelihood of requiring social care – has increased. It is possible that there may be a reverse shift if housing challenges persist and younger generations remain in the family housing unit for longer but that is unlikely to ease the pressure on the system to any significant degree.

Funding challenges

The problem is extensive – the 2011 Dilnot Review (the previous attempt at addressing the problem) estimated that one in ten adults over the age of 65 faced lifetime costs of more than £100,000 and given rising care costs since then, that estimate is now one in seven. Although not everyone will necessarily require help, for anyone that does the financial costs can be ruinous.

Yet the fact that not everyone will be affected means that it is not a given that such costs will need to be covered by money put aside and specifically earmarked for every pensioner. Consequently, there is a tendency for such costs to be ignored when planning retirement financial needs, often resulting in a crisis if and when the situation arises. This provokes strong emotions when accrued capital such as equity in the sufferer's home must be accessed to contribute to costs. The retirement living standards group is producing helpful "income needs calculators" to help members to plan their DC retirement pots. However, these tools ignore any costs arising from this issue – understandably, given the considerable uncertainties around what costs, if any, to cover.

Welfare state

It is, in essence, a perfect candidate for a collective funding system (such as, in pension provision terms, a DB pension scheme) or insurance. Given the widespread nature and impact of the issue, it clearly requires input from the state.

Successive Governments over many decades have tinkered, without a comprehensive and long-term solution being found. It is not difficult to see why. On many levels it is a challenging service to provide, and aspects are intertwined with other areas of the welfare system, such as the NHS and welfare benefits payments including state pensions. Any lasting solution will need to integrate fully with all aspects of the welfare state, necessitating consequential changes to those areas too.

The aggregate costs involved in providing a comprehensive solution through the welfare system mean that tax increases in some form to fund it are inevitable. But it is not an easy sell. The nation accepted the introduction of new taxes in the form of National Insurance contributions to at least partially fund the new NHS after the second world war, but that is a highly visible service that provides benefits to everyone throughout their lifetime. Care costs are less visible overall and not everyone will "benefit" from their tax contributions. Consequently, there is more reluctance to accept additional taxes for this purpose.

It is not surprising that no single Government has yet managed to crack the problem.

A new plan

The recent announcement by the Westminster Government of a new scheme to cover England (the devolved nations have their own systems) has been presented as the sought-after comprehensive solution. Certainly, as far as it goes, it is a sensible start.

It builds on existing proposals for integrated care systems involving health and social care. On the funding issues it takes some steps towards a comprehensive approach by introducing a new funding stream and linking the funding to that for the NHS. However, since the new funding is for both the NHS and care systems, the proportions of the funds attributed to each can vary. Indeed, the majority of the first three years' funds raised will go to the NHS to fund increased costs following the effects of the COVID pandemic.

It still falls well short of the comprehensive solution needed. It is likely that the subject will need to be revisited at some point in the not-too-distant future.

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Key features

The plan does take on some of the financial challenges. Key features of the financial aspects include:

- The plan relates to care costs; accommodation costs for those needing residential care (which is potentially the largest cost item for those affected) are outside the plan's remit.
- From October 2023 those with assets of more than £100,000 must pay care costs in full, subject to a lifetime cap of £86,000. Those with assets of between £23,000 and £100,000 must contribute on a means-tested basis from their income, but if that proves insufficient, up to 20% of their chargeable assets will be used. Those with assets of less than £20,000 will not be required to contribute from their assets.
- For recipients of means-tested support the Minimum Income Guarantee (MIG) and Personal Expenses Allowance (PEA) for care home residents will be unfrozen in April 2022 and will rise in line with inflation.
- From April 2022 a new Health and Social Care Levy will be created adding an additional 1.25% to Class 1 (employer and employee) and Class 4 (self-employed) National Insurance contributions, to both the main and higher rates. Those in employment over state pension age will also be liable for this new levy, but not on pension income. The funds raised will be ring-fenced and from April 2023 the levy will become standalone, acting as a reminder to all of its purpose.
- The rates of dividend tax will increase by 1.25% from April 2022, in an attempt to inject more equity into the funding liability.

The funding provisions (the National Insurance and dividend tax increases) will apply across the whole of the United Kingdom, with the relevant proportions of the additional monies raised also going to the devolved nations to be applied under their respective systems. The provisions for a cap on care costs exist already under the Care Act 2014, which placed those provisions of the Dilnot Review on the statute book.

Ideally, who should pay?

The decision to increase National Insurance contributions to fund the lion's share of the costs has drawn considerable criticism. Concerns have been expressed that younger people are already overburdened with taxes and other costs, and many are poorly paid compared with older generations. They will also generally be the recipients of poorer pensions both from the state and their employment.

The new system does include some features that make some attempt at increasing the contribution potentially paid by older cohorts, although the impact is likely to be less than that on poorer, younger people. Nevertheless, the principle of the social contract whereby in perpetuity today's workers contribute, on a pay-as-you-go basis, to the needs of today's elderly and needy, is a sound one which has worked effectively for state welfare and healthcare systems. It therefore seems sensible to continue that as the foundation of any new system.

However, the key underlying issue is the extent of the financial burden that falls on each generation, including the extent to which those needing care have resources that morally they should contribute towards the costs. This is bound up with bigger issues of general taxation, who should pay, and how much, and the form those taxes should take. In short, the principles behind the taxation and welfare state costs burden need revisiting in a comprehensive approach, backed by cross-party consensus to avoid future political tinkering. That is a big ask, particularly given that some aspects are the responsibility of the devolved nations, but there are precedents where a strong national interest is involved, such as the NHS and pensions automatic enrolment (AE) – so it can be done when the will exists.

Joined-up thinking – and action

In the April 2020 issue of LeGrand View I covered the proposals of the Marmot Review into health inequalities and the call for a national strategy for addressing them. The close relationship between health and wealth, particularly in respect of pensioners, suggests it is time for a new comprehensive approach involving both areas, incorporating a review of policy for funding retirement income to increase pension pot sizes. This would involve consideration of such things as higher AE contributions, more effective investment, and restrictions on how and when pension monies are utilised.

There is also a strong case for increasing the state pension, which the recent debate on the earnings-link aspect of the triple-lock threw into sharp focus. Whilst it would not have been appropriate to use this potential windfall as the tool to increase state pensions, it nevertheless demonstrated a strong movement for them to be more generous.

Increasing retirement incomes overall would increase scope for those needing social care to make a contribution to their own costs, which would help the sale of the case for increased tax or National Insurance contributions.

The reaction to the recent care proposals and the funding pressures on the NHS point to it being an opportune time for a comprehensive review of the principles behind the wider welfare state. This should build on Marmot, Dilnot and reports on taxation principles such as from the Wealth Tax Commission (see LeGrand View February 2021), crucially including consideration of the way in which the welfare state is funded. This is particularly relevant in the light of fundamental changes in the way in which wealth is now created and distributed, compared to the position immediately after the second world war when the present system was largely created.