



The costs and benefits of paying all the lowest-paid care home workers in the UK the Living Wage

by Hilary Ingham, Sally-Marie Bamford and Geraint Johnes

This report examines costs if care home workers were to be paid the Living Wage (LW), as well as the rise in National Insurance and pension contributions that would follow. It also includes a timely comparison of the costs of the new National Living Wage with those of the Living Wage.

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Low pay in care homes is widespread and varies with gender, age, location and type of provider. This report examines the increase in costs if all care home workers were to be paid the Living Wage (LW). It also considers the rise in National Insurance and pension contributions that would follow such a wage increase. Meanwhile in-work benefits would fall, so lower-income families may not enjoy significant income gains from the LW.

The government recently announced a new National Living Wage (NLW), along with proposed reductions to in-work benefits, and the report includes a timely assessment of how the costs of the NLW compare with those of the LW.

The report shows that:

- the estimated cost of paying the LW to all care home staff in 2014 would have been £830 million per annum, with the figure rising to almost £1 billion when National Insurance and pension contributions are factored in;
- a conservative estimate of the reduction in in-work benefits for a typical household was almost £1,000 per annum in 2014, implying that the LW would not necessarily bring significant increases in household income for poorer families;
- overall, the net cost of the LW is estimated to be around £500 million, implying a net public sector liability of £286 million;
- in the Summer 2015 Budget, the new NLW was introduced for those aged 25 and over. For the UK, the costs of this are estimated to be £387 million. Again, proposed changes to in-work benefits mean that many low-income households may lose out on any potential gains in income;
- while care homes with predominately self-funded residents may be able to afford higher wages, those dependent upon local authority funding are less likely to be able to, given that they often receive less money than the actual cost of care; and
- the most compelling funding option is for central government to make more funds available to care home providers, with some of the money coming from the increase in tax and National Insurance contributions.

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Executive summary

More than 1.5 million people work in the care sector in England, with over half a million of these employed in residential care and nursing homes (hereafter referred to as care homes). With the country's ageing population this figure is set to rise significantly in the future – it is likely to exceed two million by 2025. It is a female intensive sector and, increasingly, workers are born outside the UK. Many in this sector lack recognised qualifications and are poorly paid, with some earning less than the legally binding National Minimum Wage; in recent years they have seen their real pay decline. Furthermore, occupational structures within care homes are relatively flat, meaning that employees have limited career opportunities.

In recent years there has been an impetus to encourage employers to pay the Living Wage, which is set at the income level that households need in order to have a minimum acceptable standard of living (CRSP, 2015). The Living Wage, as defined by the Living Wage Foundation, is currently set at £9.15 in London and £7.85 in the rest of the UK.

The Summer 2015 Budget introduced a new 'National Living Wage', distinct from the Living Wage as advocated by the Living Wage Foundation, set at £7.20 per hour. Due to come into effect in April 2016 for those aged 25 and over, it is likely that at least half of all care workers will benefit from this pay increase.

This report investigates the incidence of earnings below the Living Wage in care homes for older people, and the costs and benefits of increasing pay to this level. It then identifies a number of potential means by which the funding necessary for this increase in wages might be found. The report also investigates some of the implications of the new National Living Wage ahead of its introduction in the first half of 2016.

Care home provision comes from private, public and voluntary organisations, with the four major private suppliers controlling 16% of the market. On the demand side, the market is monopsonistic, i.e. it has significant buyer power because of the importance of local authorities in funding care. In recent years, fiscal constraints on local authority budgets have meant that these bodies have failed to pay fee increases in line with inflation, and they are currently failing to cover the cost of residential care. There is substantial cross-subsidisation from privately funded residents to those in receipt of local authority funds (Isden *et al.*, 2013). Moreover the sector is polarised; on one hand there are care homes in affluent areas with a mainly privately funded clientele, and on the other there are care homes that are heavily reliant on local authorities for their income.

From the National Minimum Data Set for Social Care (NMDS-SC) three groups of care home staff are particularly susceptible to low pay: care workers, senior care workers and ancillary staff. While the incidence of low pay in residential care homes is almost universal, differences do emerge between men and women, the young and the old, and the nature of the care home provider. Clear regional differences are also discernible. Overall, the pay patterns that emerged reveal that it is women, the young and those working in private care homes in the North East of England who receive the lowest remuneration.

We estimate that the wage costs of paying the Living Wage to all care home staff in 2014 would have been almost £690 million per annum for England alone, and over £830 million were this to have been

rolled out across the UK. Individual ancillary staff would have received £1,359 more, with the corresponding figures for care workers and senior care workers being £1,257 and £631, respectively. Higher wages bring about increases in National Insurance (NI) and pension contributions, and when these are factored in the total cost of paying the Living Wage in all adult residential care facilities in the UK would have been almost £1 billion per year, or around £1,450 per worker per annum. Under the prevailing funding arrangements, the public sector would be liable for approximately half of this sum.

It must also be recognised that these figures relate only to those working in residential settings for older people, and that, in practice, similar pay increases would need to be in place for those working in domiciliary care. A knock-on effect of the pay increase is that earnings differentials decline; in particular, the gap between the pay of senior care workers and care workers becomes negligible. Were pay differentials to be maintained, the cost of a Living Wage settlement would be higher.

Of course, paying higher wages reduces the need for in-work benefits, which lowers the public sector's bill for the Living Wage. Some 40% of care workers currently receive at least some form of income support, be it Working Tax Credit, Child Tax Credit, Housing Benefit, Council Tax Support or Child Benefit. Assessing the savings in these funds from the pay increase is difficult, as benefit entitlement depends on household circumstances, not simply on an individual's pay. A conservative estimate would be that for the 'typical' household that we examine in this report, benefit savings in 2014 would have been approximately £19 per week, almost £1,000 per year. This income-benefit trade-off does, however, mean that the Living Wage will not necessarily bring about significant increases in household income. The move to Universal Credit should go some way to address this problem, insofar as it has been designed to make work pay.

The costs of funding a Living Wage would potentially be borne by the major stakeholders: care home operators, local authorities, private self-funding residents and central government. In terms of the ability of the care homes themselves to afford the higher pay, the evidence suggests that the better-resourced providers could afford the wage increase, although this is unlikely to be true of those care homes that are heavily dependent on local authority funding.

A potential avenue for cost savings to fund higher pay is the efficiency wage (Shapiro and Stiglitz, 1984), which advocates a pay-performance relationship whereby higher pay reduces under-performance, thereby reducing the need for costly supervision. Any productivity gains could potentially reduce employment levels, although within care, minimum staffing levels are regulated. Also, if supervisory positions were reduced, this would hamper progression opportunities which are already poor in the sector. More importantly, it must be recognised that the care sector is different from other industries. Caring is intrinsically a highly labour intensive process, and that labour is an integral part of the output. As such, productivity increases are limited without reducing the quality of care (Perrons and Tsai, 2012; Phillips and Taylor, 1980).

Exploiting the economies of scale and/or scope is another potential source of funds to pay for the Living Wage. While the evidence suggests that medium-sized facilities are more efficient than small ones, there is no simple relationship between size and costs, insofar as the largest homes with 100 or more beds are not the most efficient. Alternatively, integrating provision across the full range of care needs could generate savings in administration and certain services. Also, given the poor staff retention in the sector, savings in recruitment costs could follow from higher pay. Of course, future technological advances may alter the mode of care provision, although, as with any new technology, short-term costs would need to be covered to reap the longer-term gains, which may themselves be limited without reducing the quality of care.

It is unlikely that local authorities would be able to provide additional funds to pay the Living Wage. In the recent past, the majority have failed to increase fees in line with inflation and are now failing to pay the full cost of care for the residents they support. With council tax increases currently largely restricted to 2%, there seems little prospect that the situation will change in the short term. Furthermore, with residents' upper asset limits set to rise, local authorities will assume financial responsibility for more individuals in residential care, and it is unlikely that they will pay the resident's existing self-funded rate; it is more likely that they will try to drive down prices or move people to cheaper providers.

It is difficult to imagine that self-funders could be asked to pay more to support a Living Wage settlement. Already these residents are cross-subsidising those with local authority-funded places, and while there is a certain lack of transparency in the sector, there is a growing public awareness of this practice. In addition, it is also wrong to assume that all self-funders are wealthy.

The most compelling argument is that central government should be willing to make funds available to pay the Living Wage to all care home workers. Aside from the increases in tax and NI receipts, in-work benefit payments are also reduced. These additional funds could be ring-fenced to go back to the care home sector to pay for the Living Wage. Alternatively, better integration of social care with healthcare could release monies that are currently spent on keeping older people in hospital beds when they do not need medical intervention. Other means to fund higher pay for care home workers that have been suggested include a hypothecated tax dedicated to funding social care, and abolishing exemptions and universal benefits for older people such as NI, the winter fuel allowance, and free television licenses and bus passes.

Although the National Living Wage announced in the Summer 2015 Budget will result in pay increases for at least half of all care workers, the increases that they will enjoy are more modest than those that would come from the payment of the Living Wage. At the same time, significant in-work benefit reductions will come into force, potentially leaving low-paid individuals living in low-income families worse off.

Given the current disparity between local authority support for domiciliary care and residential care, our recommendation is that there should be a full review of the opportunities for cost-sharing right across the care sector.

As we all want good quality care later in life, both for our families and ourselves, paying care home staff a Living Wage to ensure quality of life for them and quality of care for older people seems an obvious goal that we should seek to achieve. However, we must not lose sight of the fact that higher pay is only one part of the picture, and that improving career progression opportunities and other terms and conditions for those working in care homes are also likely to be important drivers of increased quality of care, and better jobs for care home workers.

1 Background

The care home sector, taken here to refer to both residential care and nursing homes for older people is important to the economy and currently employs over half a million workers in England alone.

Furthermore, the ageing population, coupled with current unmet demands, means that as many as 1 million more adult care workers could be needed by 2025 (Franklin, 2014). There are currently 17,500 Care Quality Commission (CQC) registered care homes for older people in England and a further 3,000 non-registered establishments (Skills for Care, 2014). In England and Wales, almost 300,000 adults aged 65 and over are living in such residential accommodation, 164,000 of whom are aged 85 or over (ONS, 2014a).

As the sector seeks to expand to meet the expected increased future demand, one of its key challenges is how to address poor pay and working conditions, which are endemic. A 2013 HM Revenue and Customs report (HMRC, 2013) notes that compliance with the legally binding National Minimum Wage (NMW) is incomplete across the sector. Furthermore, with a large proportion of part-time work and other forms of flexible employment, the sector is associated with high levels of in-work poverty (Cribb *et al.*, 2013).

One way that has been suggested to improve conditions in the sector is to raise pay levels to the Living Wage (LW) which, at the time the data used in this report was collected (2014), was set at £8.80 per hour in London and £7.65 in the rest of the UK. Calculated by the Centre for Research in Social Policy (CRSP) and the Greater London Authority, the LW is designed to provide a household with a 'reasonable' standard of living. As such it is significantly in excess of the 2014 NMW of £6.30. In the UK, around 6 million workers are paid less than the LW (KPMG, 2015). It is, of course, acknowledged that pay is only one facet of working conditions, and that improvement in other areas (training and progression opportunities, for example) could also enhance the working conditions of those in the care sector, and improve quality of care.

Box 1: How is the Living Wage calculated?

The LW is set by taking minimum living costs and then translating that into an hourly wage requirement. Minimum living costs are found by asking members of the public 'what items people need for a minimum acceptable standard of living', and then costing these at national chain stores. Rent, council tax and childcare costs are also included. The calculations acknowledge that different households will have different needs, and the final living wage is a reflection of the average requirement, weighted by different household types. It is important to note that the LW is calculated on the assumption that households claim the full amount of tax credits, housing benefit and other in-work benefits to which they are entitled.

The LW and the NMW differ in that while the LW 'aims to assess needs and to provide enough for an employee and their dependants to live on', the NMW simply 'aims to provide a wage floor which is affordable for business' (Low Pay Commission, 2014). As such, when setting the NMW, the Low Pay Commission takes into account the impact a higher wage rate would have on the labour market. Also, while increases in the cost of living result in the real value of the NMW being eroded, they lead to quite steep increases in the nominal value of the LW. Contrastingly, the LW does not consider the effect of higher pay on levels of unemployment, although it does include an 'earnings cap' which prevents the LW from rising significantly faster than average earnings.

Pay in the care sector is already set to change in the coming year. In his Summer 2015 Budget, the Chancellor announced that from April 2016, employers would be required to pay employees over the age of 25 the 'National Living Wage'. Initially set at £7.20 per hour, he outlined plans for it to rise to over £9 per hour by 2020. By calling it a National Living Wage (NLW), the Chancellor disguised the fact that this was actually simply an increase in the minimum wage. Indeed, £7.20 is significantly lower than the LW

calculated by the CRSP and used by the Living Wage Foundation – for 2015, this stands at £7.85 outside London and £9.15 within London.

Box 2: Three different wages

£6.50 – National Minimum Wage: Introduced in 1999, it is a legal requirement for employers to pay at least the NMW. Set by the Low Pay Commission at a level that is not expected to result in increased unemployment, in 2014 the minimum wage for those over 21 was £6.30 per hour. It rose to £6.50 towards the end of the year, and to £6.70 per hour in October 2015.

£7.20 – National Living Wage: Introduced in the Summer 2015 Budget, employers will be required to pay staff over 25 the NLW from April 2016. Initially it will be set at £7.20, but there are plans for it to rise to over £9 by 2020. Set 65p lower than the LW, but 70p above the NMW, the NLW provides neither a minimum acceptable standard of living, nor protection for jobs. Indeed, the Office for Budget Responsibility has forecast that the introduction of the NLW will result in the loss of around 60,000 jobs (OBR, 2015a).

£7.85/£9.15 – Living Wage: Employers are not legally bound to pay their staff the LW. Set with the aim of providing enough for an employee and their dependants to live on, the LW is reviewed each year in light of changes to the costs of living. The Living Wage Foundation promotes two LWs, one for those living and working in London, which for 2015 is set at £9.15, and one for those in the rest of the UK at £7.85.

While the introduction of the Chancellor's NLW should be viewed as a positive development for those working in the care sector, the new wage will not fully address issues of low pay. It will not provide a 'living wage' in the technical sense of the term, nor will it impact on the wages of workers under the age of 25. Therefore the LW could still play an important role in improving the living standards of the large number of workers who will continue to be paid less than £7.85 per hour.

The major advantage of the LW is that it would increase the earnings of the lowest-paid and further reduce the incidence of in-work poverty. And, while there would be costs to be borne, there are wider benefits to offset these. Employers that have moved to this higher wage have reported lower staff turnover, a reduction in sick leave, better-motivated staff and an increase in productivity (Coulson and Bonner, 2015). Although there is a dearth of evidence relating directly to care homes, EHRC (2011) highlighted the emotional impact that a high turnover of domiciliary care staff has on older people. This high turnover is attributed to poor pay and conditions. Furthermore, employers have also felt that adopting the LW gave them reputational benefits (nef consulting, 2015). Of course, the care sector is specialised and an emphasis on productivity, defined by Himmelweit (2005) as the time needed to deliver a particular care service, may well be misplaced. However, in organisations that have adopted the LW, over three-quarters of both employees and employers felt that its introduction had brought about an increase in the quality of the work (*ibid.*), an outcome that would be advantageous in the context of social care.

At the national level, it has been suggested that an across-the-board adoption of the LW could lead to a loss of 160,000 jobs (Lawton and Pennycook, 2013), although there would be gains to the Treasury of £3.6 billion because of increased tax revenue and National Insurance (NI) contributions, and falls in in-work benefits. Work by Reed (2013) produces gains to public finances of a similar magnitude, but argues that the macroeconomic stimulus that the higher wage would provide would actually lead to a small increase in total employment.

Unlike the NMW or the Chancellor's NLW, paying the LW is voluntary, but there are reasons why it might be beneficial to employers to pay this higher wage. For example, the Living Wage Commission (Living Wage Commission, *op. cit.*) found that employers paying the LW enjoyed a number of business benefits such as productivity increases, improved staff retention and decreases in absenteeism. For the care sector, Carr (2014) suggests that there is little evidence to support a direct link between pay and quality of care. However, Philpott (2014) argues that investing in the social care workforce and offering

attractive career progression routes for such employees adds value to the organisation. Similarly, Devins *et al.* (2014) show that the development of comprehensive approaches to employment and training in environments without conventional progression and hierarchy can help employers develop and retain good staff, and give them a competitive advantage.

Organisations providing social care range from small and medium-sized enterprises (SMEs) to multinational companies, although smaller entities dominate. According to a recent report, 26% of residential service providers employed less than 10 workers, whereas only 3% employed 250 or more (Skills for Care, *op. cit.*). There are a number of key features of the market for social care. The market is competitive on the supply side, with Laing (2014) reporting that there are very few local authority areas where a single supplier controls 25% or more of the market. At the national level, four major suppliers – Barchester Health Care, Bupa Care Homes, Four Seasons Health, and HC-One – control 16% of provision (*ibid.*). The market is highly polarised, with a sharp divide between affluent areas where the majority of residents are self-funding, and less affluent areas where local authority funding is the norm.

On the demand side the market is monopsonistic, characterised by a higher degree of buyer power due to the purchasing power of local authorities. In recent years this has been evidenced by many of these bodies funding below inflation or, in some cases, zero fee increases. This has meant that care home operators that are highly dependent on local authority funding have faced falling profit margins. Conversely, in affluent areas, the situation is reversed with market power reverting to suppliers, i.e. care home operators. This is because many people are faced with a one-off decision relating to their old-age care provision, and they frequently have to make this decision when they are in a vulnerable situation. As a consequence, it is likely that such individuals may simply accept the charges of a residential home close by, or known to them, as they are not in a position to undertake a lengthy search process. Furthermore, for care, there are no intermediaries such as medical insurers to act as an interface between buyer and supplier. Online information and specialist financial advisors do exist, but information deficiencies in this area remain.

Another salient feature of the sector is that there is extensive cross-subsidisation between private and local authority clients, an issue exacerbated by local authority funding policy. However, despite the fact that a lack of transparency has historically surrounded this issue, this practice is now more widely understood, and in the public domain having been highlighted in the national media (The Telegraph, 2013).

There are limited economies of scale in the sector at the care home level, although additional economies are to be found at the organisational level for providers with an extensive portfolio of accommodation. One pertinent factor here is that the sector is highly regulated, particularly with regard to staffing levels. In addition, enhanced performance in the sector would come from a higher quality of care as opposed to the productivity improvements that are often sought in more traditional settings, such as manufacturing. In the care sector, labour is not only an input, it is also the effective output, which means that any productivity increases are likely to be minimal (Himmelweit, *op. cit.*).

Poor pay and limited career opportunities are key challenges for the sector over the coming decade. Many staff in the sector are poorly remunerated, with a recent report indicating that around one-in-ten care workers (across domiciliary and care home workers) are paid below the minimum wage (Gardiner and Hussein, 2015). Furthermore, despite the fact that care workers have enjoyed nominal increases in wages since 2009, in real terms their pay has declined (LSE PSSRU/Skills for Care, 2013). In addition, workers in the sector have relatively few chances for career development given the 'flat' occupational structure, and many work anti-social hours because of the need for 24-hour provision. Many in the sector are employed on part-time contracts or are in other forms of flexible employment, which have led the sector to become associated with a high degree of in-work poverty (Cribb *et. al.*, *op cit.*).

This report details the findings of work undertaken in 2015 that looked specifically at the implications of adopting the LW in the adult residential care sector. The work covers all care homes – both retirement homes and nursing homes – notwithstanding the fact that the staffing needs vary across these two types of facility, as the latter provide 24-hour medical care. Our particular focus here is on the cost of the adoption of the LW and the how this might be funded. However we acknowledge that the impending

introduction of the NLW in April 2016 is a significant policy development in this area, and therefore we also investigate the implications of this for the key stakeholders involved.

The structure of the report is as follows:

- In Chapter 2 we begin with a brief description of the data issues pertinent to the work. In particular, we discuss the limitations of using official earnings data and provide details of the sector-based National Minimum Data Set for Social Care (NMDS-SC) which we use in this study.
- This is followed, in Chapter 3, by a detailed overview of the incidence of low pay in adult residential care. Here we seek to establish whether low pay is concentrated in particular segments of the care home workforce, or whether the problem is more widespread. As is typical with any analysis of pay we look for gender bias, although the care sector is clearly female dominated. We also investigate whether there appear to be marked differences in pay practices between private, local authority and voluntary sector providers. Regional and age variations are also likely to be prevalent in the sector, and these are also investigated.
- Chapter 4 provides estimates of the costs of implementing the LW and the potential benefits that might be realised from such a pay policy. On the cost side, pay changes bring about changes in both NI and pension contributions. While the main burden of these falls on employers, there are also increased costs for employees and, in the case of stakeholder pensions, for government. Of course, increases in pay bring concomitant increases in income tax and a reduction in benefits. Notwithstanding the fact that many positive benefits can be adduced, the fact is that a funding gap remains that needs to be financed, either from within the residential care sector, or from elsewhere.
- Chapter 5 of this report provides a breakdown of where funding for care homes comes from, as a means of identifying who would be responsible for financing any funding shortfall that would arise from the implementation of a LW settlement.
- In Chapter 6, attention is turned to the issue of how the LW might be financed. We look at the position of all of the major stakeholders in the sector and attempt to assess their ability and willingness to make the necessary funding available.
- In the Summer 2015 Budget the Chancellor announced a new NLW and changes to in-work benefits. The impact of these for care workers is discussed in Chapter 7.
- Chapter 8 of the report summarises our work and provides some concluding comments.

2 The data

This chapter describes earnings data that are available to investigate pay at the occupational level. We discuss the major UK data source for occupational earnings and highlight the limitations that using this would impose on our work. We also describe a much richer, sector-based, data set that permits us to provide a more disaggregated picture of the pay of the lowest-paid workers in the care sector.

Most UK research focusing on earnings utilises the Office for National Statistics (ONS) Annual Survey of Earnings and Hours (ASHE) data, which is based on a 1% sample of employee jobs taken from HM Revenue and Customs Pay As You Earn (PAYE) UK tax records in April of each year. Information on earnings and hours is obtained from employers and treated confidentially. The survey does not cover the self-employed.

In this report we address the issue of paying the LW to the lowest-paid workers in the care home sector and, as such, we are focussing on care workers, senior care workers and ancillary staff. While the ASHE data is reported at 4-digit Standard Occupational Classification level, it has a number of shortcomings for our purpose. The primary issue relates to the sample size, particularly in the context of senior care workers. The ASHE data estimates that there are some 46,000 such workers but, with a 1% sampling frame, this means that the reported data are based on around only 460 individuals. This renders disaggregating the data to, for example, regional level, unreliable. In addition, the data do not allow us to distinguish between care workers who are employed in residential homes and those who are home carers. This is an important shortcoming, insofar as the evidence suggests that individuals working in residential homes are paid less than those in domiciliary services (Gardiner and Hussein, *op. cit.*), although the latter are often undercompensated for the time they spend travelling from one location to another. Furthermore, while the ASHE data identifies both senior care workers and care workers, there are other poorly paid, ancillary staff working in the sector – such as gardeners and cleaners – who in ASHE are spread across a number of industries, and this means that it is impossible to extract earnings data specific to such workers in the care home sector.

To overcome these problems, this work utilises the Skills for Care National Minimum Data Set for Social Care (NMDS-SC). This covers staff in a wide variety of frontline care roles and contains pay data from almost 23,000 establishments, covering more than 700,000 workers in England in 2014. The NMDS-SC contains records for almost 30% of those working in adult residential care homes. Of course, there is no assumption that the establishments reporting to the NMDS-SC are representative of those in the sector. In fact, it may be surmised that the lowest-paying providers are unlikely to supply their earnings figures, insofar as those paying below the NMW are contravening the law. A further issue that arises with this data is that employers update records throughout the year, so the information does not conform to a normal cross-section as it covers the whole of 2014. In particular, the NMW for adults rose from £6.31 to £6.50 in October 2014, although lower rates applied to younger workers. To partially overcome this problem, we have adjusted the data on the assumption that all employers who were paying the lower 2013 NMW prior to October complied with the higher rate once it was introduced. Finally, the NMDS-SC only records data for England so, where we have provided UK figures, this has necessitated producing estimates by scaling up, using information from the UK Labour Force Survey (LFS).

3 The incidence of low pay in the care home sector

To place our work in context, we attempt in this chapter to identify the lowest-paid workers in the care sector. We focus our attention on breakdowns by sex, provider, age and region. While certain predictable patterns emerge from the data, the findings reveal that pay rates below the LW are widespread.

There are 30 occupational groups employed in care homes, ranging from senior managers through to technicians, care workers and a range of ancillary staff. The three largest groups in terms of employment in England are senior care workers (63,156), care workers (390,742) and ancillary staff (116,106), and these are also the poorest-paid workers in the sector. It is on these employees that we focus our attention in this report. From the NMDS-SC we can ascertain certain stylised facts about these workers. They are predominantly female, they are on permanent contracts, they are mainly over 25 – their average age is 40 – and they work in the private sector. They are also relatively poorly educated, with only 41% of senior care workers and 12% of care workers being educated to NVQ Level 4.

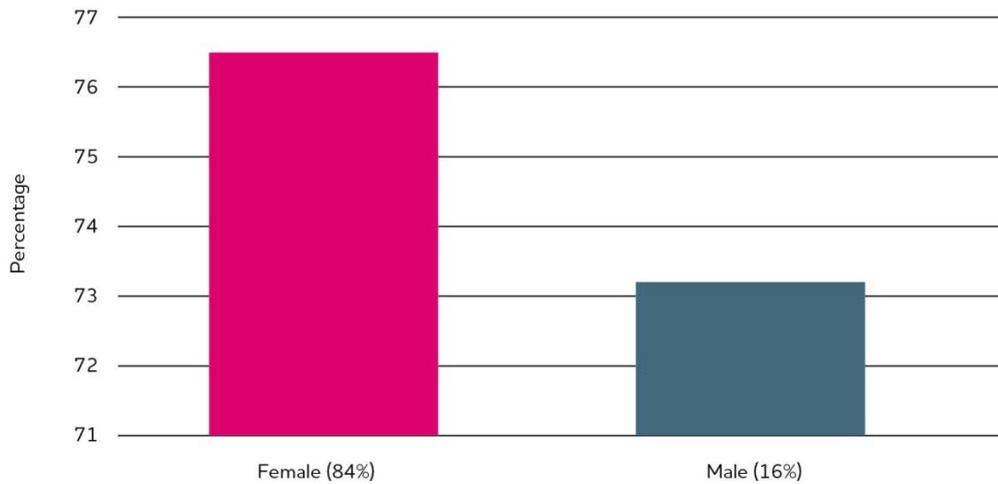
In terms of pay, the median hourly earnings for our three groups of workers in 2014 were £7.60, £6.75 and £6.50, respectively. However, the median is only a measure of central tendency. Looking at the distribution of wages as a whole within each occupation, some 1.5% of senior care workers, 4.2% of care workers and 13.9% of ancillary staff were being paid less than the NMW (the main cause of underpayment being not paying staff appropriately for sleepovers). When we consider the LW, which was set at £8.80 in London and £7.65 in the rest of the UK (we use the 2014 LW in order to match the 2014 data used), the extent of potential underpayment widens significantly to 52%, 78% and 85% for the three groups of staff.

Wage differentials by gender

Gender pay differentials in care homes are small. While the NMDS-SC data reveal a gap for senior care workers of 3.7% in favour of males, for care workers the figure only slightly exceeds 0.25%, with females receiving the higher remuneration. The gap widens when we focus on ancillary staff to 7.6%, a finding that may reflect greater job diversity among this group, with males occupying the higher-paid positions. To put these figures in context, the national gender gap in 2014 stood at 9.4% (ONS, 2014b).

The data depicted in Figure 1, which, as discussed above, relate only to England, show the gender difference in pay below the LW. On this graph, the percentages given on the horizontal axis indicate the distribution of workers across the groups. So, in this case, the majority of workers, some 84%, are female. The graph shows that while there is a degree of gender bias in pay below the LW, it is relatively small. For our three groups of care workers in total, over 76% of women are paid below the LW. For males, the figure is some 3% lower at around 73%. One explanation for this disparity between the sexes could be that men are more likely than women to occupy the higher-paid positions. However, the data revealed that this was not the case, as the highest concentration of male workers was found among the ancillary staff and the lowest among senior care workers. Further investigation did reveal, though, that the ratio of male to female staff was highest in London and the South East, which were the two highest-paying regions in our data.

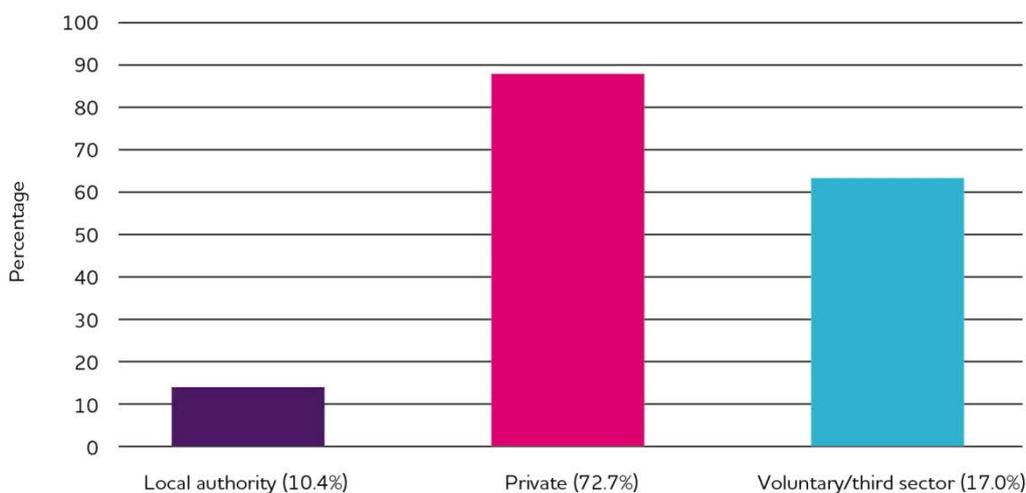
Figure 1: Incidence of pay below Living Wage by sex



Wage differentials by provider

Ownership of care homes has changed radically over the last four decades with large-scale privatisation of the sector. Delivery of adult residential care home services is now split between three main groups of providers. Figure 2 shows that the private sector now employs over 72% of the workforce, making it the dominant supplier. A further 17% of individuals work for the voluntary sector; local authorities now only account for 10% of employment. The graph also shows that any move towards the adoption of the LW would affect the private sector the most, as almost 90% of their employees are paid less than this. The figure is still relatively high for the voluntary sector at over 60%, whereas remuneration in local authority care homes is much higher, with almost 90% of employees receiving at least the LW. These findings point to the significant costs of a LW settlement for private suppliers in particular.

Figure 2: Incidence of pay below Living Wage by provider

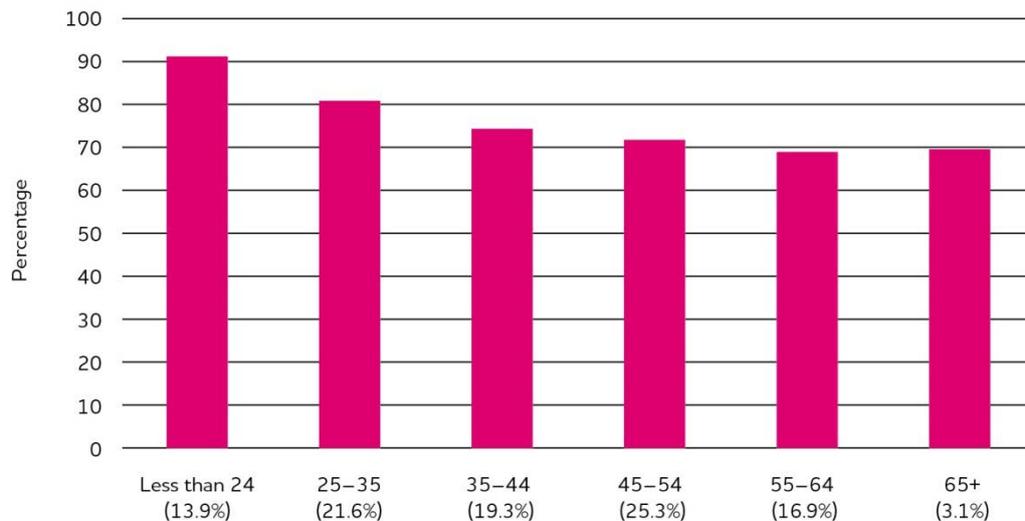


Wage differentials by age

As we would expect, the data also reveal a distinct age-wage profile as shown in Figure 3. Broadly speaking, wages increase with age; i.e. the incidence of pay below the LW declines with age. There

appears to be a slight upturn in earnings for those aged 65 and over, but this age group accounts for only a small proportion of our sample. This familiar age-wage profile is, of course, driven to some degree by the fact that the NMW is age delineated (with lower rates attached to those aged 21 and under), although the LW is not. Over 90% of those aged less than 24 are paid below the LW, although we noted that a relatively small proportion – fewer than one in five of our workers – fall into this age bracket. Around 20% of those in the 25–34 and 35–44 age brackets are similarly receiving remuneration that falls short of the LW. Even for those aged between 45 and 54, who account for a quarter of our sample, the figure is above 70% and remains at a similar level for those who are older.

Figure 3: Incidence of pay below Living Wage by age



Wage differentials by region

Figure 4 shows the usual regional pay pattern with a north-south divide, but, notwithstanding the fact that the south of England fares better than the north, pay rates below the LW are common. In the South East, which is the best-remunerated region, 60% of our care workers are paid below this rate. The comparable figure for London exceeds 70%, which sets it broadly on a par with the East and the South West of the country, despite the fact that the LW is higher in the first of these three regions. In the North East of the country almost 90% are paid less than the LW, with figures of around 80% being recorded for three more regions: the North West, the West Midlands, and Yorkshire and Humberside.

Figure 4: Incidence of pay below Living Wage by region



The evidence above shows that payment below the LW is widespread in the care sector, implying that there would be significant costs were the sector to universally adopt this higher pay policy. Of course, the financial costs of increased remuneration would fall unevenly. From the summary descriptive statistics in this section, it is clear that it is the private sector establishments where pay is lowest, and so these providers would face the greatest wage increases should the LW be adopted. Likewise, there are regional disparities, with care homes in the North East looking likely to face the largest wage increases to comply with the LW. We now turn to a discussion of exactly what these costs would be, and what mechanisms might be in place to offset them at least partially.

4 The costs and benefits of adopting the Living Wage

Increasing pay, to any degree, brings about myriad effects on a number of stakeholders. In this chapter we estimate the major costs and benefits that raising wages to the full LW, as advocated by the Living Wage Foundation, would entail. We begin with an examination of costs which can be broken down into wages, National Insurance (NI) and pension contributions. Following this, we identify channels through which the settlement could potentially be funded. These are wide ranging and include: appropriation of increases in income tax revenues and pension contributions; reductions in benefit entitlements; improvements in productivity and retention; and higher expenditure fuelled by increased income. To begin, we provide a brief overview of these issues before proceeding to a more detailed analysis.

Costs of paying the Living Wage:

1. Increased wage costs that would be borne by employers.
2. Both employees and employers would face increased NI contributions.
3. Employees, employers and the government would be liable for higher payments into the stakeholder pension scheme.

Benefits of paying the Living Wage:

1. Higher productivity and better-quality care through efficiency wage effects would benefit employers and care home residents.
2. Possible improvements in staff retention if higher wages engendered greater job commitment, which would reduce employers' recruitment costs.
3. Reduction in benefit payments, which reduces both government expenditure and the number of people reliant on in-work benefits.
4. Income tax revenue accruing to the government would increase.
5. Higher pension contributions would give employees a better income upon retirement and would reduce their reliance on state support.
6. Wider benefits to the economy would be enjoyed through higher spending by care home workers.

Breakdown of the increase in costs arising from the Living Wage

Wage costs

To evaluate the average annual pay increase needed to implement a policy in which all workers receive at least the LW, we use the following method. We calculate, for each individual worker in our dataset who receives less than the LW, the gap between the current wage and the LW. This is then averaged across all workers in the relevant occupational group (whether or not they currently receive at least the LW). The average hourly gap is then grossed up to an annual average by multiplying this gap by the individual's reported contracted hours of work. This produces the following annual costs for our three groups of employees:

- £631 for senior care workers;

- £1,257 for care workers;
- £1,359 for ancillary staff.

The total increases in wage costs that these figures generate are provided in Table 1.

Table 1: The cost of paying the Living Wage

Increase in wage costs	England (£ million)	UK (£ million)
Senior care workers	39.9	46.2
Care workers	491.2	594.3
Ancillary staff	157.8	190.9
Total	688.8	831.5

Costs based on paying the 2014 Living Wage of £8.80 in London and £7.65 in the rest of the UK

In this table the costs are identified separately for each of our categories of care workers. The second column of the table, which refers solely to England, shows these to be almost £690 million per annum. Almost £500 million per annum would be required to fund a LW settlement for care workers alone.

As noted above, the NMDS-SC database only contains records for England. Therefore, in order to provide estimates for the whole of the UK, employment weights for England, Wales, Scotland and Northern Ireland were derived from the 2014 UK Labour Force Survey (LFS), to allow us to gross up the English figures to produce UK estimates. However, while the LFS allows us to identify senior care workers and care workers separately, we cannot retrieve information about ancillary staff in the care home sector as, in the LFS, such workers are spread across many occupational groups. We therefore use the care worker weights for these staff. Note that the methodology adopted here assumes that the proportion of domiciliary care workers to care home workers is the same for all countries. This may be a strong assumption given the differing nature of health and social care provision across the countries concerned, but no obvious alternative suggests itself. On this basis, we calculate that if a LW policy were rolled out across the whole of the UK, then the cost would amount to more than £830 million with the bulk of the funds, almost £600 million, going to care workers.

Under these calculations, the figures reported reflect the costs involved if only those being paid less than the LW are given a wage increase. This obviously has an impact on pay differentials, which will become eroded. Prior to any wage increase, the differential between senior care workers and care workers was 12.6%, but the new pay settlement would see this almost completely disappear. Likewise, the gap between care workers and ancillary staff, which was almost 4%, would be totally eroded. Any move to restore these differentials would increase the costs indicated above, although we note that Geordiadis (2013) reports that there were no knock-on wage effects in care homes following the introduction of the NMW in 1999. Here, if the absolute increase in pay were awarded to all workers, the wage costs of paying the LW would rise above £1 billion. While this would not preserve the original differentials between the groups of workers, it would limit the extent of the erosion discussed above.

Increased National Insurance payments

The increases in NI costs commensurate with the wage costs discussed above are given in Table 2. We have based our calculations on the assumption that employees are not members of a contracted-out pension scheme. Here, both employees and employers face higher contributions. In England, the former will pay almost £113 million more per year, with the latter paying some £130 million more. As with the wage figures, it is care workers to whom the majority of these costs apply; the figures for senior care workers are much lower, commensurate with much lower employment levels. These figures rise to £136 million and £156 million for the whole of the UK.

Of course, NI is a system of contributions paid by workers and employers towards the cost of certain state benefits. It was initially a contributory system of insurance against illness and unemployment, and later it has also provided retirement pensions and other benefits. This means that the increased contributions generated by the LW should reduce the government's funding liability for these so, although increased NI payments are a short-term cost, they are a long-term benefit, albeit to different stakeholders.

Table 2: National Insurance costs of paying the Living Wage

Increase in National Insurance (Class 1)	England (£ million)		UK (£ million)	
	Employer	Employee	Employer	Employee
Senior care workers	6.8	5.9	7.9	6.9
Care workers	91.0	79.3	110.2	96.0
Ancillary staff	31.7	27.5	38.4	33.3
Total	129.6	112.8	156.4	136.2

Increased pension contributions

Table 3 shows the potential increases in stakeholder pension costs arising from the adoption of the LW. Our calculations here are based on the assumption that 'qualifying earnings' for the purpose of pension contributions are all pre-tax earnings. Employers can, if they choose, use pre-tax earnings of between £5,772 and £41,865 per annum as qualifying earnings. They also assume minimum contributions. These figures are much smaller than those attached to NI contributions, and the main burden falls on the employees with their total increases being £21 million in England and almost £25 million across the UK. Employers become liable for additional payments as low as £7 million for England and £8 million for the UK. The government's bill is twice that of the employers.

Table 3: Stakeholder pension costs of paying the Living Wage

Increase in pension contributions	England (£ million)			UK (£ million)		
	Employee	Employer	Government	Employee	Employer	Government
Senior care workers	1.2	0.4	0.8	1.4	0.5	0.9
Care workers	14.7	4.9	9.8	17.8	5.9	11.9
Ancillary staff	4.7	1.6	3.2	5.4	1.9	3.8
Total	20.6	6.9	13.8	24.9	8.3	16.6

The overall cost of the settlement

In order to look at the overall picture of the cost of a LW settlement, Figure 4 reports the total annual cost to the employer and the government would be £758 for each senior care worker employed. The comparable figures for care workers and ancillary staff are around twice this figure at £1,528 and £1,673, respectively. Grossed up to the national level, this implies a total bill of almost £840 million for England alone, and slightly in excess of £1 billion for the UK. As discussed in more detail below, these costs would be split more or less equally between employers and the government.

Table 4: Total cost per employee of paying the Living Wage

	Senior care workers (£)	Care workers (£)	Ancillary staff (£)
Wage costs	631	1,257	1,359
NI costs (employer)	108	233	273
Pension costs (employer and government)	19	38	41
Total	758	1,528	1,673

Potential savings generated by a Living Wage settlement

Higher productivity through efficiency wage effects

Under an efficiency wage model (Shapiro and Stiglitz, *op. cit.*), employers set wages above market levels in order to make it easier to recruit, retain and motivate staff. One outcome of this is that the framework posits a trade-off between wages and supervisory costs, since increased employee motivation and commitment reduces the need for supervision. In general, the evidence on the veracity of this claim is mixed, with Autor (2003) claiming that the evidence is inconclusive.

Caution must be exercised when evoking efficiency wage arguments in the context of care. As noted in a recent JRF/JRHT report, '[p]roviding care is not the same as making widgets' (Kennedy, 2014) – it is very different to other low-paid jobs, and any emphasis on a drive to deliver the same level of provision with fewer staff is misplaced. Caring involves the development of a relationship between the carer and the individual being cared for, which must be nurtured. In light of this, it is the care itself which is the output, which implies that standard measures of improving productivity that focus on generating the same level of output with fewer inputs (or more output with the same level of inputs) will result in a reduced quality of care (Himmelweit, *op. cit.*). Furthermore, it may be the case that vocationally-motivated staff in care homes have lower reservation wages than those lacking vocational commitment. Some argue that increasing wages could attract into the profession workers whose skills are poorly matched to the needs of employers and clients (Perrons and Tsai, *op. cit.*). What can be drawn from the efficiency wage model, though, is that higher wages may enhance motivation that could generate improvements in the quality of care, which is paramount in the sector.

In principle, better care could be delivered with less supervision; i.e. a lower ratio of senior care workers to care workers, if higher pay engenders improved job commitment. However, limited evidence exists for care homes, although Georgiadis (*op. cit.*) examined the impact of the introduction of the NMW in 1999 using primary survey data. The work found that the introduction of the NMW did reduce the need for supervision. However, the reduction in supervisory costs was smaller than the costs involved in bringing wages in general up to the NMW level. As a result, firm profitability fell, thereby confirming work by Draca *et al.* (2011) which, using a larger sample of industries, also reported that the introduction of minimum wages reduced firm profitability.

Two further issues arise. First, in the context of the above, there is some ambiguity as to which groups of workers constitute 'supervisory staff'. Under a narrow definition, supervisory duties could be confined to management. However, Georgiadis notes that case studies undertaken by the Low Pay Commission categorised certain senior care workers as holding supervisory positions, basing their claim on the seniority and qualifications of these employees. Similarly, Georgiadis himself (*op. cit.*) reports that 15% of senior care workers in his sample had supervisory duties, a figure which he found to be consistent with evidence from the LFS. The implication of this is that if raising wages could potentially reduce the ratio of senior care workers (supervisors) to care workers (supervised), this could impede progression opportunities for the latter group, which may have a detrimental effect on motivation. It may also leave

staff feeling that they lack adequate support, which could negatively affect stress levels. Further, it could increase the workload of care workers.

Second, increasing pay may increase retention rates, which are low in the sector. Using data from the NMDS-SC for England, Table 5 presents turnover figures for our three groups of workers. The second row of the table shows that almost half of all care workers have only been in position since 2012 or later. The figure for ancillary staff is lower at 34%, with that for senior care workers at 29%. Nearly 56% of senior care workers were appointed pre-2010, compared to 34% of care workers and 49% of ancillary staff. Recent work (Gardiner and Hussein, *op. cit.*) supports a link between higher pay and reduced turnover, although the relationship is fairly weak. Furthermore, the study also excludes care homes with less than 30 staff, on the grounds that a small number of leavers in such an organisation generates a high turnover rate. The study also stresses that non-financial rewards can also have a positive effect on retention, a finding consistent with the work of ekosgen (2013). Given that recruitment costs have been estimated to be as high as £8,000 per worker (iCare, 2014), improved retention could generate significant savings for employers.

Table 5: Turnover in care homes in England

In post since:	Senior care workers (%)	Care workers (%)	Ancillary staff (%)
2014 (last year)	8.8	18.5	9.8
2012–2014 (last 3 years)	28.5	49.0	34.4
2010–2014 (last 5 years)	44.3	66.0	51.2
Pre-2010	55.7	34.0	48.8

While evidence on this issue for the sector is scarce, work by Howes (2005) on San Francisco provides some guidance. In California, in 1995, home care workers were among the lowest-paid workers and were earning the minimum wage, which, at the time, was \$4.25 per hour. Following the introduction of the Living Wage Ordinance in 2000, the hourly wage rate more than doubled to \$10. At the same time, health benefits were introduced. Howes' work shows that retention rates (measured by the proportion of new workers still in post after 12 months) for new entrants into the sector rose from 39% to 74%. Furthermore, raising the wage to \$9 from \$8 (the nationwide average hourly rate at the time) was estimated to increase the retention rate by 17% and this figure would rise to 21% if health benefits were also provided in the remuneration package. In terms of the financial gains to employers, there have not been any studies that have specifically addressed this issue for care homes. Work relating to the major US retailer Walmart (Bloomberg Business, 2015) concludes that the cost of replacing a low-paid employee earning an annual income of \$21,140 would be 16% of this sum, i.e. \$3,382. While somewhat speculative, translating this across to the care sector would give a figure of just over £2,500 based on a full-time (40 hours) employee earning a LW salary of £15,912 per annum.

Changes in benefit payments and household income

Of course, higher wages reduce the need for additional monetary support via the benefits system. However, it is difficult to assess the magnitude of any savings that might be forthcoming from this channel since, while wages accrue and income tax is levied at the individual level, benefit eligibility is determined according to family circumstances such as partner's earnings and the number of dependent children. Furthermore, housing benefit varies spatially depending on the 'eligible rent' in an area, and there is no uniform rate.

In order to address the benefit payment issue, information on the 'typical' family structure of direct care workers was extracted from the 2014 Household LFS. There are two caveats in the use of this information. The first is that the data relate to both those employed in residential care homes and domiciliary care staff, and there can be no presumption that family structures are similar for these two groups. In fact, reasons can be adduced as to why they may differ, insofar as care homes need to be

staffed 24 hours per day and night work may be preferred by households with young children needing two incomes. The second is that we are unable to extract any information about ancillary staff as they cannot be identified separately in the LFS, which is our source of information on benefits.

Notwithstanding these problems, it is possible from the LFS to derive limited information on the familial situation of care workers. Figure 5 reveals that that there is no dominant family structure. Single people without dependent children account for over 20% of direct care workers, as do two other groups: a couple without dependent children with a single wage earner, and a similar household but with dependent children. Additional information from the LFS revealed that around 40% of direct care workers received some form of benefit, which might include Income Support, tax credits, Council Tax reductions and/or Housing Benefit, as shown in Figure 6.

Figure 5: Family structure of direct care workers (Household LFS 2014)

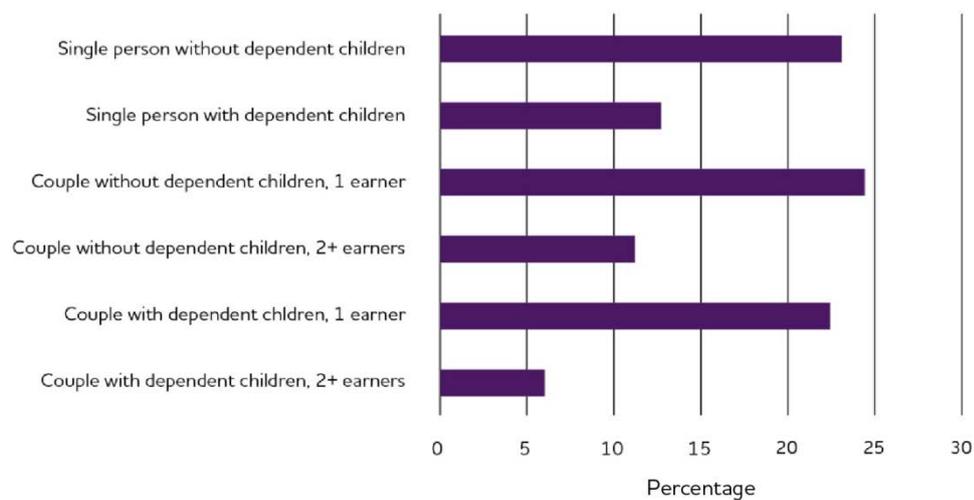
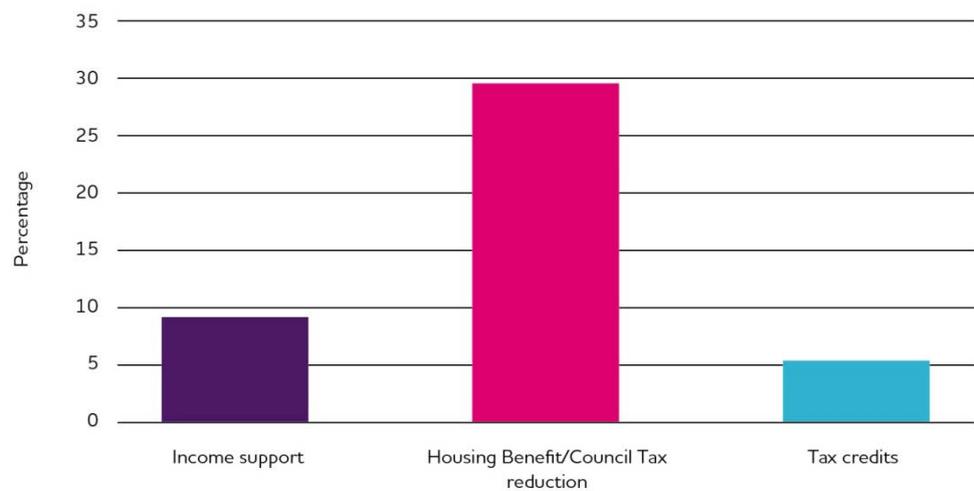


Figure 6: Direct care workers in receipt of benefits (Household LFS 2014)



To assess the impact on the benefit package that the adoption of the LW would have, we use a number of hypothetical household scenarios to generate indicative savings. These scenarios are generated under the current benefits system. The impact of the changes to tax credits and other in-work benefits announced in the recent Summer 2015 Budget are addressed in Chapter 7. In all of these scenarios we

have assumed that the individual lives outside London in a Council Tax Band C property and works 30 hours per week. The first of these, illustrated in Box 3, assumes that our representative care worker is 40 years old, has a non-working (economically inactive) partner and has two, school-age, dependent children. With only one individual at work in this household and the children already attending school, we assume that there is no need for expenditure on out-of-the-home childcare. We also assume that neither adult in the household has savings. Our benefit calculations have been carried out using the 2014/15 tax year entitlements. Raising this person's hourly wage from the legal minimum to the LW would reduce the household's benefit entitlement by £21.56 per week, which equates to £1,121.12 per annum. Of course, for a similar individual who was earning more than the NMW but less than the LW, the pay increase would not be as great and so the reduction in benefit would be correspondingly less.

Box 3: Indicative benefit savings from paying the Living Wage – Case A

40 years old, non-working partner, two dependent children, £0 per week childcare costs, working 30 hours per week, living outside London in rented accommodation.

Total benefits (Working Tax Credit, Child Tax Credit, Housing Benefit, Council Tax Support, Child Benefit):

£284.45 per week at £6.50 per hour;

£262.89 per week at £7.65 per hour.

Benefit reduction of £21.56 per week or £1,121.12 per annum.

In the second of our scenarios, illustrated in Box 4, our individual is some five years younger and his/her two children are both under four years of age. As their partner is unemployed we assume that he/she takes responsibility for childcare. Again we assume that initially this individual is earning the minimum wage. Under this configuration, payment of the LW would reduce the benefit payments to this household by £18.68 per week or £971.36 per annum.

Box 4: Indicative benefit savings from paying the Living Wage – Case B

35 years old, unemployed partner, two dependent children under four, £0 per week childcare costs, working 30 hours per week, living outside London in rented accommodation.

Total benefits (Working Tax Credit, Child Tax Credit, Housing Benefit, Council Tax Support, Child Benefit):

£284.45 per week at £6.50 per hour;

£265.77 per week at £7.65 per hour.

Benefit reduction of £18.68 per week or £971.36 per annum.

Case C, our third scenario, illustrated in Box 5, involves further changes to our assumptions, insofar as our individual is now assumed to have pre-school age children and a partner working in a minimum wage post, thereby necessitating childcare costs of £380 per week. For this household the pay increase would leave benefits unchanged.

Box 5: Indicative benefit savings from paying the Living Wage – Case C

35 years old, working partner on minimum wage, two dependent children under four, £380 per week childcare costs, working 30 hours per week, living outside London in rented accommodation.

Total benefits (Working Tax Credit, Child Tax Credit, Housing Benefit, Council Tax Support, Child Benefit):

£449.43 per week at £6.50 per hour;

£449.43 per week at £7.65 per hour.

Benefit reduction of £0 per week or £0 per annum.

Our final scenario in Box 6 is similar, although our hypothetical individual is now a single parent. The benefit reductions that would be generated by uplifting the pay of this individual from the NMW to the LW amount to £18.68 per week or £971.36 for the year.

Box 6: Indicative benefit savings from paying the Living Wage – Case D

35 years old, single parent, two dependent children under four, £380 per week childcare costs, working 30 hours per week, living outside London in rented accommodation.

Total benefits (Working Tax Credit, Child Tax Credit, Housing Benefit, Council Tax Support, Child Benefit):

£540.52 per week at £6.50 per hour;

£521.84 per week at £7.65 per hour.

Benefit reduction of £18.68 per week or £971.36 per annum.

Grossing up the figures to give an overall indication of the benefit savings that would accrue from the introduction of a LW ideally requires detailed information on family structure and household composition of those working in the care sector. Simply extrapolating from our cases above will produce an overestimate of the savings that would be generated, as we have looked at low-income households who all receive the full range of benefits. Working from our baseline average benefit reductions, which from the figures above is £14.73 per week, with 40% of care workers receiving some form of benefit, gives a total figure of approximately £300 million per year. However, while the LFS data revealed that almost 30% of those in the sector received some form of financial assistance with housing, the corresponding percentages for income support and tax credits were far lower: less than 10% for the former and around 5% for the latter. On average then, there is around a 15% probability of receiving one or more of these benefits, and applying this to our total of £300 million gives an approximate estimate of benefit savings of £45 million per annum. This figure should, of course, be treated with caution. In terms of comparable estimates, our figures for benefit reduction and increased tax revenue, which total £200 million, equate to 44% of the gross public cost of implementing the LW (some £498 million). Gardiner and Hussein (*op. cit.*), using a microsimulation model, cite a figure of 48%, which indicates some comparability between their study and this one.

Of course, from the individual's perspective, it is the overall effect on their household income that is important, assuming that resources are distributed equally within the family (Himmelweit *et al.*, 2013). For the individuals in the scenarios above, the gross increase in annual earnings from the adoption of the LW would be £1,794. However, the individual would be liable for increases in tax, NI and stakeholder pension contributions of £358.80, £215.28 and £14.35, respectively, meaning that take-home pay would rise by

£1,205.57 per annum. Taking benefit reductions into account, for the individuals we have looked at the annual financial benefits of the LW would be:

- Box 3: £84.45 (0.7% of gross annual LW earnings from a 30-hour week, £11,934);
- Box 4: £234.21 (2%);
- Box 5: £1,205.57 (10%);
- Box 6: £234.21 (2%).

Notwithstanding the non-pecuniary advantages of income from work as opposed to benefit transfers, certain individuals would actually only be less than £100 better off per annum as a result of a LW settlement. This is primarily because of the fall in entitlement to benefits.

Looking forward, the roll-out of Universal Credit continues and will not be completed until 2017. This effectively replaces the means-tested benefits that low-paid workers were entitled to claim; Income-related Employment and Support Allowance, Income Support, Child Tax Credit, Working Tax Credit and Housing Benefit will all be subsumed into a single payment. Reworking our four cases above under the new scheme left the reduction in benefits that would come about as a result of paying the LW unchanged. Note, though, that these figures do not reflect the welfare changes announced in the Summer 2015 Budget. The implications of these are discussed in Chapter 7.

Although we have concentrated on the impacts of the LW for the major stakeholders in the sector, there will be additional effects. Given that care home workers feature among the lowest-paid employees in the country, they are likely to have a high marginal propensity to consume, and so additional earnings are likely to be spent as opposed to saved. In turn, this increased expenditure could have knock-on local multiplier effects (Moretti, 2010), with a recent estimate of the magnitude of a regional multiplier by Nakamura and Steinsson (2015) of 1.5. In addition to this, the government would receive VAT payments from this new spending. Some caution must be exercised here. Any increases in job remuneration that are simply financed through reducing benefit payments will not represent new spending, and it is therefore important not to over-emphasise the potential of a move to the LW to deliver significant knock-on effects.

5 Who pays for care?

In the work above we have identified the various costs and benefits associated with paying the LW to workers in adult residential care homes. In summary, while there are benefit savings to buffer the increase in earnings, there can be no supposition that a direct one-to-one trade-off exists. First, the figures above highlight that the costs of the higher wage will exceed any benefit savings, leaving a not insubstantial funding gap. Second, these costs and benefits accrue to different stakeholders. Thus, for example, while higher wages bring about higher income tax remittances, it is the care homes themselves that must pay the higher wage, while the government enjoys the increased tax revenue. In this section we take a preliminary look at who pays for care in order to see who would be liable to fund a LW.

Funding for care homes comes from three main sources, as illustrated in Box 7. First, there are those residents who are wholly responsible for their costs of care. These account for 44% of care home residents (LaingBuisson, 2014). Just under half of care home places are, to some degree, funded by local authorities, with eligibility for such support being means-tested. Currently, the rules operate around a capital band of £14,250 to £23,250 in England and Northern Ireland, with the figures for Scotland being £15,250 to £24,750. Capital is assessed as all assets, including property, unless this is 'disregarded', as would be the case if a spouse remained in residence, or if a care home stay was deemed to be only temporary.

Box 7: Who pays for care?

401,000 people live in residential care homes across the UK, of these:

- 44% are fully self-funded;
- 36% are fully local authority funded;
- 13% are partially self-funded;
- 7% receive full NHS funding.

Those with assets below the lower level receive full local authority funding, although they are expected to contribute their pension minus £23.50 per week (£24 in Wales) towards the costs of their care. Individuals with assets within the band receive partial local authority funding. For every £250 an individual has as capital, he/she would contribute £1 per week for their care. In Wales, individuals with assets below £23,250 receive free care. Since 1 April 2015 a deferred payments system has been in operation, which means that individuals no longer have to sell their property to finance care home fees. Instead the council will fund these and reclaim the debt, either upon death or when the individual chooses to sell their house. The interest chargeable for this facility is currently 2.65%, but the figure is subject to review every six months. At present, 36% of care home residents receive full local authority funding, with a further 13% receiving partial support.

The 2014 Care Act contains changes to these rules that, although originally planned for April 2016, will now come into force in 2020; these follow from the Dilnot recommendations (Commission on Funding of Care and Support, 2011). They include a lifetime care cost cap of £72,000, above which the State will meet the cost of eligible social care needs, subject to a new daily living cost charge equivalent to £230 per week. There is also a significantly increased capital limit for the financial means test for residential care, which will change to £118,000. In addition, care accounts will be introduced, which will track personal expenditure towards meeting eligible care needs.

The remaining 7% of care home residents are fully funded by the NHS and this support is not means tested. Residents in this category are typically critically ill and frequently nearing the end of life.

From the above, the figures suggest that approximately half of care home funding comes from the public sector, with the other half coming from the private sector. Table 6 shows that this results in a total financial liability for each of these sectors of approximately £500 million per annum, with the net public sector cost totalling £286 million.

Table 6: Private and public costs of a Living Wage settlement in the UK care sector

	£ million
Wage costs	831.46
National Insurance costs (employer)	156.43
Pension costs (employer and government)	24.27
Total costs	1,012.16
Split 50:50 private and public sectors both liable for	506.08
Minus – for public sector component:	
Income tax	175.41
Benefit reductions	45.00
Net public sector cost	285.67

6 How can the sector pay the Living Wage?

In this chapter we turn our attention to how the funds to pay the LW might be found. We focus on the major stakeholders – care homes, local authorities, central government and residents – in an attempt to identify possible sources of revenue. At the end of the section we look to see whether technological advances in the near future might provide at least a partial solution to the problem. Of course, this issue is long-standing and our work acknowledges the two most recent reports into the future of social care; namely those of the Commission on Funding of Social Care and Support in 2011 (*op. cit.*) and the Independent Commission on the Future of Health and Social Care in England which reported in 2014 (The King’s Fund, 2014).

Care homes

The initial cost of the LW will fall on the care homes themselves, and so the first question that arises is whether they can afford it; the answer to this question depends upon their profitability. According to healthcare specialist William Laing, quoted in *The Sunday Times* (2014), there is a polarisation of profitability in the care home sector depending on whether the home is largely privately or publicly funded. Data for 2012, presented in Table 7, reveal that the average EBITDARM (earnings before interest, tax, depreciation, amortisation, rent and management fees) as a percentage of income for the UK was 28%, with little variation between the smallest care homes with less than 40 beds (25.7%) and the largest ones with 100 or more beds (28.9%)(Knight Frank, 2013).

Table 7: Key performance indicators by size of care home (2012)

Bed size category	Average weekly fee (£)	Staff cost as % of income	Staff cost per resident	EBITDARM as a % of income	EBITDARM per bed (£)
under 40	620	58.6	18,888	25.7	7,352
40–59	624	57.0	18,500	27.5	7,793
60–79	639	56.3	18,692	29.3	8,290
80–99	611	58.9	18,714	28.0	7,879
100+	600	56.6	17,659	28.9	7,917
All UK	622	57.2	18,489	28.0	7,870

Source: Knight Frank (2013)

Regionally, Greater London, the East and the South East outperformed the rest of the UK due to a combination of high fees and high occupancy rates. Northern Ireland and Wales returned the lowest profitability, due to their high staff costs relative to fee income. What these figures suggest is that there is variation in the profitability of care homes, and that therefore some homes are better placed than others to absorb the extra costs associated with paying the LW.

In all spheres of industry, imminent wage increases lead organisations to seek cost reductions in other areas, so we begin here by looking to see whether we can identify scope for such savings in the care home sector. Not surprisingly, staff costs dominate in the sector with Knight Frank (*op. cit.*) reporting that these account for almost 60% of income, with little variation across homes of differing bed capacity. As noted above, within the care sector, staff are the linchpin of the service provided and the relationship between carer and the individual being cared for must be nurtured over time. The nature of this relationship would be severely compromised by any attempt to deliver the same level of care with fewer staff. In light of this, even if higher wages bring about improved performance, this is more likely to be

reflected in a higher quality of care rather than care delivered with fewer staff. Furthermore, the scope for reducing staffing levels is limited due to regulations governing minimum staffing levels.

An alternative would be to replace relatively expensive staff, such as managers and senior care workers with those on a lower pay grade, i.e. care workers. Again, this strategy would be feasible if paying the LW reduced supervisory requirements. However, reducing the number of more senior positions limits career opportunities for those on lower grades. If higher pay reduced turnover then there would also be savings from recruitment costs. Given the low retention rates evident in the sector, this avenue is one that could potentially generate revenue to fund a higher wage. These are issues which are currently being addressed, with the CEO of Skills for Care, Sharon Allen, noting '[w]ith up to 60,000 vacancies on any given day in our sector, it is clear finding and keeping quality people is a real problem' (Skills for Care, 2015).

Evidence on the efficacy of such staffing efficiencies is limited, but LaingBuisson (2013) report that larger providers such as Four Seasons Healthcare and Bupa Care Services have succeeded in making savings in this way, although the work suggests that the scope for future savings is limited. A more radical solution may be found via the substitution of labour, which is relatively expensive, with cheaper capital. Given that technological change will doubtless drive the model of provision in the future, it is discussed in detail at the end of this section.

Economies of scale offer another potential source of cost savings, although there is evidence to suggest that it is medium-sized care homes with 60–79 bed capacity that are the most scale efficient. Recent data by Knight Frank (*op. cit.*) reported in Table 7 cite an EBITDARM of £8,290 per bed for these, which compares to a figure of £7,917 for establishments with capacity of 100 or more beds. The report attributes this to the fact that the largest homes tend to charge relatively low fees. The least cost effective were homes with less than 40 beds, with an EBITARDM of £7,352. These findings suggest that merger or expansion of smaller institutions can – up to a point – realise cost efficiencies that could release resources to pay higher wages. Of course, organisational economies are likely to be present for providers with multiple homes, since many administrative functions such as marketing and other services will be common across sites, and costs can be shared.

Other efficiency savings have also been posited by a number of authors. D'Amico and Fernandez (2012) suggest that these could be realised if local authorities improved commissioning. In particular, they found local authorities to be the most inefficient providers, suggesting that using homes run by the private sector and voluntary organisations would be cost effective. These findings concur with Laing (*op. cit.*) who also recommended that local authorities should withdraw from their own provision of residential care. However, Forder and Allan (2011) report that increased competition in the sector has driven down prices, thereby suggesting that some of the least efficient providers had already exited the sector. The authors also report that falling prices have led to reductions in the quality of service delivered. Furthermore, the extent to which additional savings across the sector can be realised through this channel is limited by the fact that local authority care homes now only account for 10% of the total.

One potential avenue to reduce the costs of residential care would be to provide a more integrated service. Thus, at present, many older people move into sheltered accommodation but may then have to move into residential care as their needs increase, or if their current accommodation fails to meet their needs, e.g. moving from an upper level flat to one on the ground floor may become necessary. Some of these individuals will then need to make a further move into a home with nursing facilities if their requirements increase. If these differing accommodations were available at a single site then providers could enjoy economies of scope, and services such as catering and gardening could be common.

Many providers are reliant on local authority funding, and the problem here is that as their budgetary pressures have increased, many councils will no longer cover the costs of care, as illustrated in Table 8. The figures in the table show that the average local authority payment did not cover the cost of provision in any of the eight English regions. The average underpayment was £56 per resident per week, ranging from £50 in the North East to £68 in London. These figures represent percentage shortfalls in income of around 10%.

Table 8: Care home fees

Region	Actual cost (£) – includes a ‘reasonable’ profit margin	Self-funded charge (£)	Local authority payment (£)
East Midlands	540	615	486
East Anglia	560	630	504
North East	505	565	455
North West	525	580	473
South East	605	660	545
London	685	770	617
South West	600	710	540
West Midlands	540	616	486
Average	563	636	507

Source: Valuing Care, cited in *The Telegraph* (*op. cit.*).

From 2020, care home operators are likely to be faced with further downward pressure on fees. With the upper capital limit rising to £118,000, local authorities are going to become responsible for fees currently charged to some full-funders. It is likely that local authorities are going to try to drive down the self-funding price to the prevailing council rate. If care home operators try to resist such pressure then local authorities may threaten to move residents to cheaper homes.

The issue of ageing populations and care has also received much attention at the European level under the eHealth banner. In terms of service provision, telemonitoring, which is a telemedicine service whereby the health status of individuals can be monitored automatically and at distance, is seen as an increasingly important mode of service provision. It is particularly useful for people with chronic long-term illnesses such as diabetes and chronic heart failure, both of which disproportionately affect the elderly (CEC, 2008). There has been significant industry investment to support telemonitoring, yet its use remains restricted to pilot projects. Where it has been used, patient compliance is high. Furthermore, while at present there is limited evidence on the cost-effectiveness of such systems, potentially they offer fewer adverse health events, prescriptions and hospital stays, and a better quality of life. Many of the ‘players’ in the telemedicine industry are SMEs that do not have the financial strength to go it alone in rolling out this technology, so it is inevitable that either public sector support will be required, or that advances can be made through public-private initiatives.

However, even during the economic crisis there was growth in eHealth with global telemedicine growing from \$9.8 billion in 2010 to \$11.6 billion in 2011. This trend is expected to continue, with the figure projected to reach \$27.3 billion in 2016 (CEC, 2012) and \$43.4 billion by 2020 (EC, 2015). This growth has been driven, at least in part, by the realisation that care and the so-called ‘silver economy’ are promising markets.

Several factors are, however, still impeding the widespread take-up of eHealth. First, there is a lack of awareness of the system and confidence in it among both patients and professional staff. To overcome this barrier, the European Commission has supported activities aimed at increasing digital health literacy. This began with the Competitiveness and Innovation Programme that started in 2013, and continues under Horizon 2020. The focus of these initiatives is to develop evidence-based clinical guidelines on telemonitoring for health and social care workers. Second, as with many technology-based solutions, the initial set-up costs of services such as telemonitoring are high. Third, there is still limited large-scale evidence as to the cost-effectiveness of eHealth services and tools. Finally, there is a lack of transparency about how any data that would be collected under eHealth services might be used.

In terms of the implications of eHealth for residents in care homes, it is unlikely that telemonitoring can be used to replace personal care for many residents. As Himmelweit (*op. cit.*) notes, and as discussed

above, there are limits to the degree to which technology can replace personal care, since technological innovation cannot substitute for the long-term nurturing relationships formed between a carer and the individual they are caring for. This suggests that the direct savings for care homes are likely to be minimal. However, if technological advances can be used for regular monitoring of those with lower dependency levels, resources could potentially be diverted towards those with the greatest need.

Local authorities

In recent years, local authority funding to care homes has declined. A report by LaingBuisson (*op. cit.*) found that, for 2013/14, 62 of the 133 councils that provided data gave below-inflation care home fee rises. Of these, 31 gave no increase at all. Another 56 awarded increases of between 2% and 2.9%, which allowed providers to keep pace with inflation, and only 15 increased baseline fees by 3% or more. As noted above, the fees that local authorities have been paying fail to cover the full cost of care, and the evidence above suggests that this gap is widening.

As was mentioned at the outset of this report, though, local authorities have significant market power when negotiating bed prices and have been successful in pursuit of this aim. Notwithstanding this, it was reported in *The Times* in March 2015 that 30% of council tax receipts are channelled to the care of vulnerable adults. With responsibilities for services ranging from street cleaning to education, it seems unlikely that local authorities are going to be prepared to devote a higher proportion of their budgets to adult social care. If additional funds are to come from this source, there will need to be substantial increases in council tax. Currently, such increases are limited to a maximum of 2% per annum, and there seems to be very little prospect of any reversal in this policy in the near future. It is estimated that this freeze has cost local authorities £2.8 billion in lost revenue (CIPFA, 2015) and so the emphasis has been on efficiency savings as opposed to increasing spending.

However, in addition to paying for residential care, local authorities also partially fund domiciliary care for older people. Despite the fact that the prevailing ethos is a preference for older people to remain supported in their own homes as opposed to entering residential care, there could be some homogenizing of the funding of the two types of service. Under prevailing arrangements, those receiving domiciliary care pay less than those in a care home, even taking 'hotel' costs into account; if the charges were raised to commensurate levels, this would provide additional funding for local authorities. A further suggestion is that care could be better targeted; i.e. a comprehensive analysis of the needs of each individual care recipient should be carried out and a care plan specific to their particular needs should be drawn up, in order to avoid providing costly, unnecessary services. This suggests that there should be a full review of the opportunities for cost-sharing right across the care sector.

Self-funders

It is difficult to imagine that self-funding residents in care homes could be asked to pay more for the cost of a LW settlement. First, such individuals are already cross-subsidising residents whose fees are paid by local authorities. Allied to this is the fact that although there is not full transparency within the sector, there is a growing public awareness of this practice. Second, it would be incorrect to equate self-funding with rich. Currently, anyone with assets valued at more than £23,250 is required to meet the full costs of their care, a figure which may seem comparatively low, although the average savings of Britons aged over 75 was only £21,648 in 2014 (AOL, 2014). Furthermore, under the Dilnot proposals (Commission on Funding of Care and Support, *op. cit.*) the upper capital limit will rise to £118,000, meaning that the number of self-funders will fall as local authorities will be required to fund more care places. A recent estimate by The Strategic Society Centre, based on the original implementation date of April 2014, suggests that this would have been around 35,000 individuals by April 2016 (Lloyd, 2014).

Central government

It seems appropriate that central government should assume more responsibility for funding of residential care for older people, in line with how it funds the NHS. Furthermore, more integration between health and social care, as envisaged under the provisions of the 2014 Care Act, could alleviate

strains on hospital beds, which are too often occupied by older people who do not require medical intervention.

A number of proposals have actually been put forward as to how the government might find the funds to support social care. First, as discussed above, payment of a LW to workers in the sector would bring the government the twin benefits of an increase in tax revenue and a decrease in benefit payments. It might therefore seem equitable if these funds went back into the care home sector to help cover the costs of the LW. However, there is no strong precedent for ring-fencing funds.

Furthermore, the economic theory underpinning the rationale for paying minimum wages remains underdeveloped. There is, for example, no model that can be used to help us understand the employment effects of paying minimum wages where these are accompanied by welfare benefits that may be withdrawn as the minimum wage rises. Just as an increase in benefits is likely to affect labour supply, a transfer of funds from government to employers is likely to affect labour demand. The outcome of implementing a system whereby central government partially funds the payment of a LW in the care homes sector, resourcing this from savings in benefit payments, is uncertain, and would depend on the relative shifts in supply and demand.

Another way of securing government funding would be to increase tax in order to raise the necessary funds. According to the Institute for Fiscal Studies (2015a), a 1% rise in all rates of income tax would raise £5.5 billion. Alternatively, the same increase in all employee and self-employed NI contribution rates would raise £4.9 billion, while raising the main rate of VAT by the same amount would raise £5.2 billion. However, tax increases are unpopular with the electorate. VAT also has the additional drawback of being a regressive tax. An alternative might be to increase income tax for the highest paid, although the problem with such a policy is that there is a high degree of uncertainty about how much revenue this would generate, if indeed it generated any at all (Institute for Fiscal Studies, 2015b).

Another option would be the introduction of a hypothecated tax whereby a specified proportion of tax that individuals paid would be earmarked for social care (Keable-Elliott, 2015). The efficacy of this rests on the belief that people will be less hostile to paying more tax if they are sympathetic to the cause for which it is intended. Such taxes also serve to increase transparency, accountability and trust (Le Grand, 2003; Doetinchem, 2010). Survey evidence for 2014 reported in Keable-Elliott (*op. cit.*) revealed that between 33% and 48% of those surveyed would be willing to pay a tax dedicated to the NHS, whereas two-thirds of individuals would not be prepared to pay higher income tax to fund it.

There are, however, compelling arguments against the introduction of such a tax. First, governments do not like to be constrained in the manner in which they choose to spend their revenue. There are those, such as Doetinchem (*op. cit.*), who argue that health provision should be determined by need rather than by tax. Furthermore, tax revenues are cyclical, which means that monies available for care would be subject to macroeconomic shocks and, as noted in the Barker Report (The King's Fund, *op. cit.*), it is during economic slumps that the need for care may be at its greatest, as individuals are more susceptible to illnesses such as depression. There are mechanisms that can overcome the cyclical problem, such as the creation of a stabilisation fund, but this then breaks the direct link between tax revenue and spending.

An additional problem with hypothecation is that it can hamper government attempts to stabilise the economy (Le Grand, *op. cit.*). In a boom, tax revenues would increase, so either taxes would need to be cut, or more would need to be spent on care to mop up this increase in tax. Both of these would fuel the boom. The reverse would happen in a slump. Tax revenue would decrease, so either less would have to be spent on care, or taxes would need to increase to maintain revenue. Both spending cuts and increased taxation would exacerbate any recession.

There are examples of hypothecated taxes in the UK, such as those levied from TV licences and road tolls. Furthermore, some of the tax revenue from the sale of tobacco is spent on health. In summary, 'Hypothecating tax revenue is not inherently right or wrong. It depends crucially on whether citizens trust its government to spend tax revenues wisely or not' (Doetinchem, *op. cit.*).

Another source of revenue that is available to government is the money that would be raised by removing or reducing the universal benefits that older people receive. The winter fuel allowance alone costs the Exchequer some £2 billion, with a further billion required to fund free bus travel. Free TV licences cost an additional £600 million. There is also the fact that those working beyond pensionable age are exempt from NI contributions and receive tax concessions.

Despite the slow growth of recent years, real GDP increases are forecast to rise at an average rate of over 2% per year (HM Treasury, 2015). Higher government revenue arising from this growth could provide funds to support the implementation of the LW in the care sector without the need to reduce the flow of resources elsewhere. However, there will be intense competition among government departments for this money.

At the same time, however, the government is committed to reducing the budget deficit and, according to the Office for Budget Responsibility (OBR, *op. cit.*), between 2009/10 and 2019/20, the budget balance is forecast to move from a post-war record deficit of 10.2% of GDP to a small surplus of 0.3%. This represents a turnaround of 10.5% of GDP, which equates to £190 billion in today's terms. As of 2014/15, approximately half of the planned reduction, some 5.2% of GDP or £94 billion, will have been achieved.

7 The Summer Budget 2015

In the Summer Budget in July 2015, the Chancellor made the surprise announcement of the National Living Wage (NLW) of £7.20 per hour, which will be paid to all those aged 25 and over from April 2016. The figure will increase to 60% of median earnings by April 2020, with the OBR estimating that this will give an hourly rate of £9.35 (OBR, 2015b). This, of course, is significantly different to the LW; not only is it a much lower rate, it is set by central government as opposed to being determined by an independent body (namely the Greater London Authority for the capital and the Centre for Social Policy at Loughborough University for the rest of the UK). In many ways it is more akin to a rise in the NMW, albeit one that confers no gains to those aged less than 25. For the care sector, Gardiner (2015) estimates that between 50% and 60% of workers will benefit from the new NLW.

In order to evaluate this new policy alongside the impacts of adopting the LW, we have calculated the costs and benefits to the various stakeholders of the £7.20 hourly rate. For comparison purposes, the figures in Table 9 are presented alongside estimates pertaining to the 2015 LW, which is £9.15 for London and £7.85 for the rest of the UK. These figures need to be interpreted with caution, as we can only estimate the counter-factual – i.e. what the individuals in our sample would have been earning in April 2016 in the absence of the NLW – and our estimates have certain shortcomings. First, they compare an April 2016 figure for the NLW with one for actual wages that relates to 2014. This means that the estimates of the costs to employers of implementing the new NLW policy are biased upwards, if individuals would in any event have been awarded any pay increases during the intervening period. To partially mitigate this we have assumed that all individuals who were receiving the 2014 NMW would have seen their pay increase with rises in the NMW. We therefore assume that all individuals who were receiving the NMW in 2014 are updated to the 2015 rate of £6.70 per hour before we evaluate the costs of moving to the NLW, with the commensurate rates applied for young people. We also assume that all individuals who were paid above the 2014 NMW but below the 2015 rate would be receiving £6.70. Of course, in the absence of the NLW, the NMW would almost certainly have been raised again in 2016 and this also adds a slight upwards bias to our estimates.

Second, the LW is set to be increased in November 2015, which means our figures that examine the costs of paying the LW are biased downwards. Third, both sets of estimates assume that both the size and composition of the workforce remain the same. In reality, wage increases may well lead to a reduction in employment, even if the nature of care delivery means that this may only be a modest fall. Looking specifically at the NLW, one of its key features is that younger workers are completely excluded. This may encourage employers to increase the number of people aged less than 25 that they employ, and to reduce the number of the now more relatively expensive workers aged 25 and above, a strategy that large UK supermarkets are likely to employ according to a recent report (Moody's, 2015). In summary, the figures only deliver 'ball park' estimates to allow us to assess the relative costs of the different pay schemes.

The figures in Table 9 reveal the costs of the NLW are significantly less than those for the LW, compared to both the 2014 LW and the higher 2015 one. This is unsurprising, given the lower value of the NLW, but the extent of the difference suggests a concentration of care worker pay near or above the NLW (but still below the LW). Wage costs under the NLW are approximately one-third of those for the original 2014 LW for both senior care workers and care workers, and half of those for ancillary staff, at £221, £448 and £640, respectively. NI and pension costs are also commensurately lower. For employers in the care home sector, the NLW rate will be more affordable than a LW and many will have budgeted for an increase in the NMW at the end of 2015. For an employee in the sector working 30 hours per week, the extra 50p per hour from the £7.20 NLW (as opposed to the £6.70 NMW) leads to a net pay increase of some £780 per annum. Receipt of a £7.65 hourly rate would mean an increase of 95p per hour, which would result in this figure rising to £1,482 per annum. At the aggregate level, the total wage costs of the NLW would be £318 million for the UK. Adding to this, NI costs for the employer and pension costs for both the employer and government brings the total sums involved to £387 million. Under our earlier assumption that these costs would be borne more or less equally between the private and public sectors, the cost to each sector would be £194 million. The government's share would be

offset by a £46 million increase in income tax receipts and any benefit savings arising from the major changes to the system that will come into force.

Table 9: Total cost per employee of paying the National Living Wage/November 2014 Living Wage

	Senior care workers (£)	Care workers (£)	Ancillary staff (£)
Wage costs			
National Living Wage	221	448	640
November 2014 Living Wage	816	1,466	1,560
NI costs (employer)			
National Living Wage	39	82	120
2015 Living Wage	142	278	325
Pension costs (employer and government)			
National Living Wage	7	13	19
November 2014 Living Wage	24	44	47
Total			
National Living Wage	267	462	850
November 2014 Living Wage	982	1,788	1,931

Moving to the comparison between the NLW and the higher £7.85 (£9.15 in London) LW, the gulf widens. The wage costs for senior care workers are now £816, while those for care workers are £1,466, figures that are more than three times higher than the figures for the NMW. The wage costs for ancillary staff of £1,560 are more than double the cost under the NLW. The extra 65p benefit (£1.95 in London) from this higher LW, over and above the £7.20 offered by the NLW, would give our worker an additional annual gross income of £1,014, with this figure again being based on a 30-hour week. Nationally, the higher rate LW would increase wage costs by £972 million. With the addition of NI payments from employers and pension contributions from both employers and government, the total costs of such a pay settlement would be £1,188. Dividing this equally between the private and public sectors implies a liability for each of £594 million. The additional income tax that the higher wage would generate would provide £153.6 million set against the government's commitment, and there would be additional savings from the introduction of the new benefit regime.

In summary, while the NLW will benefit many workers in the care sector, it will not deliver the same level of remuneration as the LW, which implies that many individuals in the care sector will still not be receiving a wage that is sufficient for them to enjoy an acceptable standard of living.

Alongside the announcement of the NLW came details about a forthcoming £12 billion reduction in benefits spending by 2019–2020. The biggest change announced was the cuts to in-work allowances, i.e. the amount families can earn before tax credits/Universal Credit (UC) start to be withdrawn. This amount has fallen from £6,420 to £3,850. Alongside this there is also a reduction in the total amount of benefit that a family can receive, the removal of tax credit/UC entitlement for third and subsequent children, and the abolition of the family element in Child Tax Credit/UC. Working age benefits, including Income Support, Child Benefit, Housing Benefit, Child Tax Credit and Working Tax Credit, are to be frozen for the next 4 years. In real terms, this amounts to a reduction in these benefits, which have already seen up-ratings below the rate of inflation since 2013. Hood (2015) contends that with these cuts, 7.4 million families in work will lose £280 a year on average, with the poorest families set to lose £1,000 per annum.

Overall, OBR (*op. cit.*) estimates that the direct impact on gross wages of the NLW is much less than monies saved from the tax and benefit changes. Importantly, however, these two are not substitutes, as they are targeted at different groups. Thus, whereas the NLW supports those with low hourly pay, tax credits and other benefits support households with low family incomes. In terms of the care sector, many workers look set to gain from the introduction of the NLW as Hood (*op. cit.*) identifies females and those working part-time as the groups set to benefit from the introduction of the higher hourly rate.

Whether their increases in earnings offset their tax increases and benefit reductions will depend upon their household circumstances; those in high-income households will gain, as they would not have been claiming tax credits or benefits in any case. However, those in low-income households will lose. For this group, the NLW offers a much poorer package than receipt of the LW and the current benefit system retained. Indeed, it is important to note that the LW is calculated on the assumption that households claim the full amount of tax credits, Housing Benefit and other in-work benefits to which they are entitled. If such benefits are reduced, but living costs remain the same, then the LW will automatically rise. Thus these benefit changes mean it is likely that the LW will need to increase, widening the gap between the NLW and the true LW.

8 Conclusion

Social care is an important industry, with residential homes alone providing employment for over half a million workers in England; with our ageing population, this figure is likely to rise significantly in the coming years. Individuals working in the sector shoulder a high level of responsibility as they are caring for some of the most vulnerable people in society. Despite this, remuneration in the care sector is poor, with some workers not even receiving the statutory NMW. In this report we identify the costs and benefits, for all stakeholders in the sector, of adopting the LW.

We find that the direct wage costs of rolling out the LW to all senior care workers, care workers and ancillary staff in adult residential care homes in England to be slightly below £700 million, a figure that rises to over £800 million were the policy to be adopted across the whole of the UK. For the staff groups we examined, the highest wage increases, some £1,359 per annum, would go to ancillary staff. Care workers would receive a slightly lower figure of £1,257, with senior care workers receiving £631. Additional NI and pension contributions follow from the higher wage, both for employees and employers, although these are of a much smaller order of magnitude. Pension contributions also rise for both employees and employers, with additional payments required from the government. Pay increases that are restricted to the lowest earners erode previous wage differentials; if these differentials were to be maintained, in part at least, the costs of raising minimum pay levels in the sector up to the LW would exceed £1 billion.

There are monetary savings to be made from higher wages, as entitlement to in-work benefits will fall. These are somewhat harder to quantify, insofar as benefits are assessed on household circumstances and not on individual earnings. Our conservative estimate suggests that, on average, the LW could serve to reduce benefits by around £14 per week for low-income households. This, allied with the fact that only about 40% of care workers receive benefits, suggests a significant funding gap of over £285 million, although this would be partially offset by the increased spending that would accompany higher wages.

In terms of whether care homes could afford to meet the costs, the evidence is mixed. The care home sector is polarised. At one end there are residential homes, normally in affluent areas, where the majority, if not all, of the residents are self-funding. These residents typically pay for provision at rates that exceed those paid by local authorities, often cross-subsidising residents paid for by the public purse. Where care homes cater primarily for privately funded residents, it may be reasonable to assume that the providers could afford to pay the LW and still return a reasonable profit. For care homes in less affluent areas, with the majority of residents funded by their local authority, the LW is unlikely to be affordable. Over recent years the fees that homes have received from local authorities have failed to keep pace with inflation, and many are now receiving council payments that fail even to cover the costs of care. Local authorities enjoy monopsonistic power in the commissioning of beds and are able to drive down prices to non-economic levels; there is no indication that this situation will change in the near future, as councils continue to face fiscal strictures. In fact, the problems may be exacerbated when the upper income band for local authority support increases, as councils will assume responsibility for the fees of more care home residents. As they become an even more dominant buyer in the market, their bargaining power will increase.

Where local authorities could look to release funds for the payment of a LW is the disparity in their payments for residential and domiciliary care. Under current provision, those receiving support at home pay less than those in a care home. A review of payment schemes across the whole of the care sector, accompanied by the consideration of more tailored provision for domiciliary care, could lead to more equitable cost-sharing across modes of service delivery, and may facilitate the identification of potential cost savings.

Although higher wages may well lead to improved performance, within the care sector this is likely to be seen as an increase in the quality of care, rather than delivering the same level of care with fewer staff. Economies of scale offer another source of cost savings to fund a LW settlement, with the evidence suggesting that it is medium-sized care homes that are the most efficient; this would imply that smaller providers may want to merge, otherwise they are likely to struggle to pay the LW. Another area where

savings may be made is in staff retention, as NMDS-SC data reveal that turnover rates in care homes in England are high. Better pay and conditions could improve retention, thereby lowering recruitment costs. For the future, developments in eHealth could bring about additional cost savings, but the deployment of the necessary technology will involve significant up-front costs, and there will be additional training costs for care workers as the technology is deployed. Furthermore, technology is a far from perfect substitute for personal care, which involves the nurturing of a relationship between the carer and the individual being cared for, and it is crucial that both the quality and the nature of care are not jeopardised.

While one option would be to charge self-funding residents more to fund the LW, this is unlikely to happen. Currently, there is significant cross-subsidisation between these private payers and those on local authority funding. Notwithstanding the fact that the care home sector does lack some transparency, the existence of this practice is now in the public domain, and it is hard to see how the payment gap between the two types of resident could widen.

This means that to make the LW a reality, funds would be needed from central government, either directly or through relaxing constraints on local authorities' ability to raise council tax revenue. Without this additional funding, while the various channels described in this report may provide some funds, they will not be sufficient. The core of the problem is that the social care sector is underfunded, and improvements at the margins will not eradicate the problem.

In the current economic climate the government is still committed to deficit reduction and is unlikely to be willing to simply increase spending on social care. Indeed, there can be no assumption that any monies saved from benefit payments would be earmarked to go back to the sector. Various proposals have been put forward to ensure the sound financing of social care in the future; these include dedicated taxes and the removal of selected benefits made available to older people, such as NI exemptions, the winter fuel allowance and free TV licences and bus passes.

In terms of what funding the government would need to find, the sums are actually relatively small. The gross cost of funding a LW settlement for England for 2013/14 would have been in the order of £500,000, which could have been offset by increases in NI and benefit reductions amounting to £220 million. Funding the LW would bring significant benefits in the form of improved staff retention and motivation, and a reduction in in-work poverty.

In the Summer 2015 Budget, the Chancellor announced that a new NLW of £7.20 per hour will be introduced in April 2016. This replaces the NMW, but will only be paid to those aged 25 and over. While around 50–60% of care workers are likely to benefit from this, it only represents a 50p per hour increase over the current NMW, and is a much less generous settlement than rolling out the full LW. This is reflected in our estimates, which show the costs of the £7.20 hourly rate to be significantly lower than those of the November 2013 LW that we have modelled in this report. Alongside this, the budget also announced significant reductions in in-work benefits. Although the NLW and benefit reduction measures are not designed to 'balance', insofar as they are targeted at different groups – low-paid individuals versus poor families – some individuals on low pay living in families with low household income could be worse off from these measures. With a significant number of senior care workers, care workers and ancillary staff receiving benefits, it is likely that some of these individuals will be faced with falling incomes, as the increases in their wages as a result of the NLW will not offset the reduction in in-work benefits. In summary, the commitment to paying the lowest paid more is welcomed, but the current measures look unlikely to fully resolve the problem of poor pay in the care sector.

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