

Adult Social Care and Property Rights

Brian Sloan*

Abstract – This article assesses the possible impact of the Care Act 2014 on the provision of social care for elderly and disabled adults in England, focusing particularly on the balance between ensuring adequate care and affecting the property rights of the recipients of social care, their families, and others who might have legal or moral claims to their property (especially via inheritance). The article uses the European Convention on Human Rights to measure the Act's implications, arguing that normative problems remain despite the Act's general compatibility with the Convention.

Keywords: human rights, succession, carers, dignity

1. *Introduction*

The legislation that became the Care Act 2014 was described as ‘the biggest change in the law governing...care and support in England since the National Assistance Act 1948’,¹ and it was sufficiently contentious for the Labour opposition to try to stop the relevant Bill from receiving a second reading in Parliament due to its alleged inadequacy.² This article’s aim is to assess the likely impact of the Act (specifically Part 1) on the provision of social care for the increasing numbers of

* College Lecturer & Fellow in Law, Robinson College, Cambridge. Email: bds26@cam.ac.uk. This article arises out of an Early Career Fellowship at the Centre for Research in the Arts, Social Sciences & Humanities (CRASSH), Cambridge. The author is very grateful for the Fellowship, and for the comments on earlier drafts of this article of attendees of a CRASSH Work in Progress Seminar in January 2015, a presentation during the “Challenging Ownership” stream of the Socio-Legal Studies Association Annual Conference at the University of Warwick in April 2015 (attendance at which was facilitated by a Cambridge Humanities Research Grant) and the anonymous referees.

¹ House of Lords & House of Commons Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill: Report* (2012-13, HL 143, HC 822) para 41.

² See T Spencer-Lane, *Care Act Manual* (Sweet & Maxwell 2014) para A1-015 for discussion.

adults³ who require it, particularly on the balance between ensuring adequate care and affecting (via ‘asset-based welfare’)⁴ the property rights of the recipients of social care, their families, and others who might have legal or moral claims to their property (especially via inheritance). In doing so, it evaluates whether the rhetoric surrounding the Act matches reality. Much of Part 1 of the Act was commenced in April 2015,⁵ although the implementation of some of its most significant funding reforms (including a lifetime cap on care costs to be met by an individual) has been delayed from 2016 until 2020.⁶

Social care raises difficulties for doctrinal legal scholars, given its political and fiscal sensitivity. While legislation must underpin it, it is not wholly or even mainly a distinctly *legal* issue. This was seemingly recognized by the Law Commission in its report that effectively led to the Care Act⁷ (alongside the Dilnot report on care funding).⁸ The article therefore seeks to measure

³ See, eg, R Wittenberg et al, *Projections of Demand for and Costs of Social Care for Older People in England, 2010 to 2030, under Current and Alternative Funding Systems: Report of Research for the Commission on Funding of Care and Support* (PSSRU Discussion Paper 2811/2, 2012).

⁴ L Murphy, ‘Asset-based Welfare’ in Science Direct, *International Encyclopaedia of Housing and Home* (Elsevier 2012), cited by N Hopkins and E Laurie, ‘Social Citizenship, Housing Wealth and the Cost of Social Care: Is the Care Act 2014 “Fair”?’ (2015) 78 MLR 112.

⁵ See, eg, Explanatory Notes to the Care Act 2014, para 420.

⁶ Department of Health, ‘Letter from Rt Hon Alistair Burt MP: Delay in the Implementation of the Cap on Care Costs’ (July 17, 2015), <<https://www.gov.uk/government/publications/delay-in-the-implementation-of-the-cap-on-care-costs>> accessed 20 February 2016.

⁷ See, eg, Law Commission, *Adult Social Care* (Law Com No 326, 2011) para 1.19; cf, eg, J Herring, *Caring and the Law* (Hart Publishing 2013); Hopkins and Laurie, (n 4); MA Fineman, *The Autonomy Myth: A Theory of Dependency* (New Press 2004).

⁸ Commission on Funding of Care and Support, *Fairer Care Funding* (2011).

the impact of the Care Act using the European Convention on Human Rights ('ECHR'),⁹ whose status in domestic law can require even the most doctrinal scholar to engage with difficult political and resource-based questions. In doing so, the author hopes to avoid the tendency in legal approaches to social care described by Carr (inspired by Harvey),¹⁰ namely 'an adherence to the rule of law which operates to embed neo-liberal rationalities [whereby a] muscular black letter law stance applies even when there is available an alternative legal device – in this instance dignity and human rights – and the popular will to soften the consequences for those most vulnerable to the retreat of the state'.¹¹

Other human rights treaties are more obviously tailored to the protection of those requiring social care, such as the UN Convention on the Rights of Persons with Disabilities 2006.¹² However, the ECHR (for the time being)¹³ is incorporated into English Law via the Human Rights Act 1998 and directly enforceable by individuals. Carr and Hunter argue that '[h]uman rights...provide an important plank of the legal welfare which has supplanted the social welfare of the immediate post-war period'.¹⁴ At the same time, they criticize some recent judicial approaches¹⁵ for the 'the mentality...that if law just tries harder, perhaps through the deployment of human rights, it can do

⁹ See, eg, T Murphy, *Health and Human Rights* (Hart Publishing 2013) 9-13 for a justification of the use of 'human rights legal method' in relation to health.

¹⁰ D Harvey, *A Brief History of Neoliberalism* (OUP 2005).

¹¹ H Carr, 'Rational Men and Difficult Women – *R (on the application of McDonald) v. Royal Borough of Kensington and Chelsea* [2011] UKSC 33' (2012) 34 *Journal of Social Welfare & Family Law* 219, 220.

¹² See, eg, L Pritchard-Jones, 'Night-time Care, Article 8 and the European Court of Human Rights: A Missed Opportunity?' (2015) 37 *Journal of Social Welfare & Family Law* 108; R Kayess and P French, 'Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) 8 *Human Rights LR* 1.

¹³ Cf, eg, N Walker, 'Our Constitutional Unsettling' [2014] *Public Law* 529, 545-46.

¹⁴ H Carr and C Hunter, 'Are Judicial Approaches to Adult Social Care at a Dead-End?' (2012) 21 *Social & Legal Studies* 73, 79.

¹⁵ Carr and Hunter's targets were specifically those in *YL v Birmingham City Council* [2007] UKHL 27.

its work', opining that they 'inspire little hope in the law as a means to solve contemporary problems'.¹⁶ In any case, the Convention can legitimately be considered the most influential human rights treaty for English Law, and an analysis of adult social care's compatibility with it has value. It is significant that the Care Act has specifically extended the protection of the Human Rights Act to all those receiving care from a registered (and potentially private) provider either in their own home or a care home, where the care is arranged *or* at least partially funded by a local authority ('LA') under various provisions.¹⁷ As will become clear, however, the deferential approach of both the European Court of Human Rights ('ECtHR') and (somewhat less explicably) national courts as regards social policy means that the level of compatibility of the law in this area has in significant respects not undergone a fundamental shift following the Care Act. The threshold for a breach of the Convention, as regards both the provision and funding of care and its consequences for property rights, is very high. This, in turn, demonstrates the limitations of the Convention in safeguarding certain types of right.

The article's body is divided into two inevitably overlapping sections. Section 2 considers the provision of care, and Section 3 considers the funding of care. A reason for the overlap is that resources will often be a key consideration in decisions on the provision of care. As Herring correctly asserts, while '[t]here is much to be welcomed' in the proposals embodied in the Act, 'at the end of the day it will be the levels of funding which are key, rather than legislative structure'.¹⁸

¹⁶ Carr and Hunter (n 14) 86.

¹⁷ Care Act 2014, s 73. Cf Health and Social Care Act 2008, s 145 and *YL v Birmingham City Council* [2007] UKHL 27.

¹⁸ Herring (n 7) 143.

2. The Provision of Social Care

A. The Mechanics of the Care Act

Adult social care is the responsibility of LAs in England, though ‘few...are now involved in the direct delivery of care and support services’, with most services operated by private, for-profit providers.¹⁹ It is distinct from health care provided by the National Health Service, and it will be seen in the next section that this distinction assumes particular importance as regards the funding of care. It is frequently criticised, and Herring asserts that ‘whether the ability to care [for oneself] is seen as an aspect of health promotion or dealing with the consequences of ill-health, the distinction [between free health care and potentially charged-for social care] is hard to justify’, and has suggested that ‘the division has more to do with attempts to cut costs to the state, while holding on to the claim that health services are provided free at the point of delivery, than...being based on...sound policy’.²⁰

In any case, the NHS operates via the Secretary of State’s duty to ‘continue the promotion in England of a comprehensive health service designed to secure improvement’²¹ ‘in the physical and mental health of the people of England’²² and ‘in the prevention, diagnosis and treatment of physical and mental illness’.²³ There is no equivalent statutory definition of social care in

¹⁹ D Kelly, ‘Editorial: Reflecting on the Implications of the Care Act 2014 for Care Providers’ (2013) 7 *Journal of Care Services Management* 74, 74.

²⁰ J. Herring, *Medical Law and Ethics*, 5th edn (OUP 2014) 51.

²¹ National Health Service Act 2006, s 1(1).

²² National Health Service Act 2006, s 1(1)(a).

²³ National Health Service Act 2006, s.1(1)(b).

Final Version to be published in (2016) 38(2) Oxford Journal of Legal Studies.

legislation,²⁴ although it has been said that it ‘supports people of all ages with certain physical, cognitive or age-related conditions in carrying out personal care or domestic routines’.²⁵

It is also significant that the NHS mostly owes duties to the population as a whole, whereas LAs owe some enforceable public law duties to individuals.²⁶ In essence, the National Health Service Act 2006 imposes a duty on a clinical commissioning group to provide health care services to patients to such extent as it considers necessary to meet all reasonable requirements.²⁷

According to the Government, ‘[t]he Care Act and supporting guidance does not seek to alter the boundary of responsibilities of [LAs] and the NHS’,²⁸ despite the Act’s emphasis on integration.²⁹ Section 22 of the 2014 Act largely codifies the approach of the courts in interpreting the old boundary,³⁰ as well as giving the Secretary of State the power to make regulations to close the gap between health and social care. An LA may not ‘meet needs...by providing or arranging for the provision of a service or facility that is required to be provided under’³¹ the 2006 Act, unless

²⁴ See, eg, Herring (n 7) 136-138.

²⁵ Commission on Funding of Care and Support, (n 8) 4.

²⁶ Spencer-Lane (n 2) para 1-268; see also, eg, *R (McDonald) v Kensington and Chelsea Royal London Borough Council* [2011] UKSC 33 [69] (Baroness Hale). E Wicks, *Human Rights and Healthcare* (Hart Publishing 2007), ch 2 considers whether there is a right to healthcare in the context of the NHS.

²⁷ National Health Service Act, s 3; *R (Condliff) v North Staffordshire Primary Care Trust* [2011] EWCA Civ 910 [4] (Toulson LJ).

²⁸ Department of Health, *Response to the Consultation on Draft Regulations and Guidance for Implementation of Part 1 of the Care Act 2014* (Cm 895536, 2014).

²⁹ Care Act 2014, s 3; Department of Health, *Care and Support Statutory Guidance: Issued under the Care Act 2014* (2014) ch 15.

³⁰ See, eg, National Assistance Act 1948, s 21(8); *R v North and East Devon HA ex p Coughlan* [2001] QB 213 (CA).

³¹ Care Act 2014, s 22(1). There are similar boundary issues with respect to housing law: s 23; see, generally, Department of Health (n 29) [10.23].

that would be ‘merely incidental or ancillary to doing something else to meet needs’³² and ‘the service or facility... would be of a nature that the [LA] could be expected to provide’,³³ although the basic rules are finessed. The Government sought to clarify the statutory guidance³⁴ following feedback,³⁵ but refused to provide examples of what ‘merely incidental or ancillary’ means.

In the 2001 case of *R (on the application of A) v Lambeth London Borough Council*, Scott Baker J. described how:

Community care legislation has grown piecemeal through numerous statutes over the last half century. There are many statutes aimed at different targets whose provisions are drawn in differing language. Each Act contains its own duties and powers. Specific duties have to be distinguished from target or general duties and duties from discretions. Sometimes a [LA] has several ways in which it can meet an obligation. Some provisions overlap with others and the inter-relationship is not always easy.³⁶

Spencer-Lane nevertheless notes that ‘the need for law reform did not arise solely because of an inadequate legal structure’.³⁷ He emphasizes the Law Commission’s ‘more fundamental reasons for reform’, its criticism of adult social care law for ‘perpetuating out-dated and discriminatory concepts’, and its contrasting of ‘the strong duty to provide residential care to older and disabled

³² Care Act 2014, s 22(1)(a).

³³ Care Act 2014, s 22(1)(b).

³⁴ Department of Health (n 29) [6.68].

³⁵ Department of Health (n 28) 36.

³⁶ [2001] EWHC (Admin) 376 [24]. See, eg, National Assistance Act 1948, Chronically Sick and Disabled Persons Act 1970, Disabled Persons (Services, Consultation and Representation) Act 1986, National Health Service and Community Care Act 1990.

³⁷ Spencer-Lane (n 2) para A1-006.

people, with the less-certain rights to community and home-based care provision' in the National Assistance Act 1948.³⁸ His views on the Act and social care law in general must of course be read in light of the fact that he was engaged as a lawyer on the associated Law Commission project.

According to the Department of Health, the Care Act 2014 'creates a single, consistent route to establishing an entitlement to public care and support for all adults with [relevant] needs'.³⁹ The Act also seeks to prevent care and support needs from arising, and to reduce and delay them.⁴⁰ It contains a new framework for the 'safeguarding' of adults at risk of abuse or neglect,⁴¹ which will in principle contribute to its protection of human rights.⁴² It includes oversight provisions⁴³ and attempts to ensure continuity of care in case of private provider failure.⁴⁴ As well as the funding reforms already mentioned and to be analysed in detail later, the Act puts personal budgets on a statutory footing for the first time,⁴⁵ and it will be seen that these assume significance in the funding context.

The Care Act opens with a new statutory well-being principle.⁴⁶ It provides that '[t]he general duty of a [LA], in exercising a function under [Part 1] in the case of an individual, is to

³⁸ Spencer-Lane (n 2) para A1-006; Law Commission (n 7) eg Part I. See also Chronically Sick and Disabled Persons Act 1970, and, eg, *R (McDonald) v Kensington and Chelsea Royal London Borough Council* [2011] UKSC 33 [65] (Baroness Hale).

³⁹ Department of Health, *Factsheet 2* (2014) 1.

⁴⁰ Care Act 2014, s 2.

⁴¹ Care Act 2014, ss 42-47; see also ss 67-68 on independent advocacy.

⁴² See, generally, Herring (n 7) 279-284, but cf 298-311.

⁴³ Care Act 2014, ss 53-57.

⁴⁴ Care Act 2014, ss 58-52.

⁴⁵ Care Act 2014, s 26; Department of Health, *Factsheet 4* (2014); see, generally, C Needham and J Glasby, *Debates in Personalisation* (Policy Press 2014).

⁴⁶ Care Act 2014, s 1.

promote that individual's well-being',⁴⁷ with 'well-being' defined as encompassing several elements⁴⁸ and a number of matters being specified as mandatory relevant considerations.⁴⁹ While the principle is laudable, the Government has admitted that it is 'designed to set out the overarching purpose of care and support into which specific duties...fit, rather than require a[n] [LA] to undertake any particular action in...itself'.⁵⁰ It is, however, intended to signify 'a shift from...duties...to provide particular services, to the concept of "meeting needs"'.⁵¹ Both the Law Commission⁵² and Spencer-Lane⁵³ compare the well-being principle to the governing welfare principle in the Children Act 1989.⁵⁴ But the welfare principle is more mandatory in nature because welfare must be a court's 'paramount' consideration where it applies. Slasberg and Beresford criticize the absence of a *standard* of well-being in the Care Act's principle,⁵⁵ and the final statutory guidance crucially states that '[t]he Care Act's approach to "meeting needs", as opposed to duties to provide...services, is not intended to place additional requirements on [LAs]'.⁵⁶ One judge confirmed that the section 1 duty 'is worked out in many particular respects and most of them, ...when properly understood, accord a large measure of discretion to the [LA]'.⁵⁷

⁴⁷ Care Act 2014, s 1(1).

⁴⁸ Care Act 2014, s 1(2).

⁴⁹ Care Act 2014, s1(3).

⁵⁰ Department of Health (n 28) 11.

⁵¹ Department of Health (n 29) paras 1-9, 10.10.

⁵² Law Commission (n 7) para 4.1.

⁵³ Spencer-Lane (n 2) para 1-003.

⁵⁴ Children Act 1989, s 1.

⁵⁵ C Slasberg and P Beresford, 'Government Guidance for the Care Act: Undermining Ambitions for Change?' (2014) 10 *Disability & Society* 1677, 1677-8.

⁵⁶ Department of Health (n 29) para 23.16.

⁵⁷ *R (on the application of SG) v Haringey LBC* [2015] EWHC 2579 (Admin) [23] (Deputy Judge John Bowers QC).

Many of the details of what the Act introduces are contained in regulations. This arguably makes the provisions more obscure and less accessible than they would be if they were in the Act itself. It should be noted, however, that previously most details about assessment were in mere *guidance*.⁵⁸ The same is true of eligibility for non-residential care under the old system,⁵⁹ and charging for non-residential services.⁶⁰ So there has in fact been an ‘upgrade’ in the authority of provisions governing some matters, which could be a positive development for the rule of law.

Under section 9 of the 2014 Act, ‘[w]here it appears to a[n] [LA] that an adult may have needs for care and support, the authority must assess’⁶¹ ‘whether the adult does have [such] needs’,⁶² and if so what they are.⁶³ This ‘needs assessment’ must be carried out ‘regardless of the authority’s view of’⁶⁴ the adult’s level of need⁶⁵ or financial resources.⁶⁶ The only clear exception to the duty is where a person with capacity and who is not experiencing or at risk of abuse or neglect refuses the assessment.⁶⁷ Further, ‘[t]he eligibility determination cannot take place until an assessment has been completed, except...where the [LA] is meeting urgent needs’.⁶⁸ As for the financial assessment (considered in the next section of this article), the statutory guidance concedes

⁵⁸ Spencer-Lane (n 2) para 1-134.

⁵⁹ *ibid* para 1-148.

⁶⁰ *ibid* para 1-219.

⁶¹ Care Act 2014, s 9(1).

⁶² Care Act 2014, s 9(1)(a).

⁶³ Care Act 2014, s 9(1)(b).

⁶⁴ Care Act 2014, s 9(3)

⁶⁵ Care Act 2014, s 9(3)(a).

⁶⁶ Care Act 2014, s 9(3)(b); Department of Health (n 29) para 6.13.

⁶⁷ Care Act 2014, s 11.

⁶⁸ Department of Health (n 29) para 6.12.

that it ‘may in practice run parallel to the needs assessment’, but is adamant that ‘it must never influence an assessment of needs’.⁶⁹

A focus on continual assessment (without necessarily meeting needs) has been criticized.⁷⁰ The Law Commission recommended a two-tier approach, the first of which involves the LA providing information advice and assistance without assessment.⁷¹ This is reflected in the distinction between sections 2-6 and 9-13.⁷²

Spencer-Lane notes that ‘[t]he Care Act clearly delineates between the needs assessment and decisions about service provision’, since the duty in section 9 (intended to have the same effect as section 47(1) of the NHS and Community Care Act 1990)⁷³ ‘does not contain any reference to the care and support that might be provided following an assessment’ (set out in section 8).⁷⁴ The consequence of this separation is apparently that ‘[o]nly once needs have been identified should they be evaluated against an eligibility framework and a decision made about whether the person is entitled to care and support’.⁷⁵ Lord Brown in *R (McDonald) v Kensington and Chelsea Royal London Borough Council* held that resources were relevant to the needs assessment under the pre-Care Act law.⁷⁶ That said, in the later pre-Care Act Supreme Court case of *R (KM) v Cambridgeshire County Council*, it was held that resources were irrelevant to the assessment of needs but relevant to whether it was necessary for the LA to provide a service, the nature and extent

⁶⁹ Department of Health (n 29) para 6.12.

⁷⁰ Spencer-Lane (n 2) para 1-093.

⁷¹ Law Commission (n 7) paras 5.3-5.16.

⁷² Spencer-Lane (n 2) para 1-093.

⁷³ *ibid* para 1-099.

⁷⁴ *ibid* para 1-100.

⁷⁵ *ibid* para 1-100.

⁷⁶ [2011] UKSC 33 [8], applying *R v Gloucestershire County Council, ex p Barry* [1997] AC 584 (HL). Cf [2011] UKSC 33 [72] (Baroness Hale).

of any necessary service, and the reasonable cost of such a service.⁷⁷ It seems likely that the judiciary will approach the new provisions in the same way.⁷⁸

The assessment will be the first stage of establishing whether a person has eligible needs counting towards the new cap on care costs (if and when that cap is implemented),⁷⁹ considered in the next section of this article. As a result, ‘people and their families will have a significant economic interest in establishing that they have eligible needs [by requesting an assessment] because that is when the meter starts ticking for...free care and support’,⁸⁰ and the statutory guidance anticipates that ‘a significant number of people who would previously have arranged and paid for their own care may approach the [LA] for support in accessing care’, or a needs assessment.⁸¹ This makes the theoretical irrelevance to the needs assessment of financial resources particularly significant.⁸²

The statutory guidance concerning the nature of the assessment is extensive,⁸³ but the system truly hinges on the ‘eligibility determination’.⁸⁴ The Act introduces a new statutory national eligibility threshold for social care (establishing the level of need that an LA must meet),⁸⁵ ultimately contained in the Care and Support (Eligibility Criteria) Regulations 2015.⁸⁶ An LA can choose to meet non-eligible needs in addition.⁸⁷ The Law Commission had recommended that the

⁷⁷ [2012] UKSC 23; see, eg, Herring (n 7) 147-49.

⁷⁸ Spencer-Lane (n 2) para 1-099.

⁷⁹ *ibid* para 1-093; Care Act 2014, s 15.

⁸⁰ Spencer-Lane (n 2) para 1-093.

⁸¹ Department of Health (n 29) para 23.43.

⁸² Spencer-Lane (n 2) para 1-101.

⁸³ Department of Health (n 29) ch 6.

⁸⁴ Department of Health (n 29) para 6.53.

⁸⁵ Care Act 2014, s 13; s 18.

⁸⁶ SI 2015/313 (‘CSECR’).

⁸⁷ Care Act 2014, s 19.

Final Version to be published in (2016) 38(2) Oxford Journal of Legal Studies.

legislation anticipate either a national threshold or local thresholds,⁸⁸ but the government was firmer on the importance of a national threshold.⁸⁹ Nevertheless, differences in interpretation will remain.⁹⁰ The Act's Impact Assessment admits that pre-Act '[a]ccess to care and support varies across the country, with different authorities setting different thresholds for eligibility and very broad variations in how these thresholds are interpreted', such that '[i]ndividuals who have the same needs can be eligible for care and support in one [area] but not...another..., even where the [LA] nominally sets the same local threshold based on national guidance'.⁹¹ Moreover, the Government's intention (and Slasberg and Beresford's prediction)⁹² is that the threshold will replicate pre-existing practice, which continues discrimination based upon area of residence and limits the Act's impact.

The intention behind the draft regulations for the Care Act was to replicate the pre-Act 'substantial' needs threshold.⁹³ That threshold was contained in mere statutory *guidance* (at least in respect of non-residential care),⁹⁴ the *Fair Access to Care Services* ('FACS') guidance.⁹⁵ The FACS guidance contains four bands of needs – 'critical', 'substantial', 'moderate' and 'low' – used by LAs to specify which level they would meet, taking account of their resources and other factors.

⁸⁸ Law Commission (n 7) para 6.17.

⁸⁹ Spencer-Lane (n 2) para 1-149.

⁹⁰ *ibid* para 1-149.

⁹¹ Department of Health, *Impact Assessment: The Care Act 2014: Regulations and guidance for implementation of Part 1 of the Act in 2015/16* (IA No 6107, 2014) para 2.1.

⁹² Slasberg and Beresford (n 55) 1689.

⁹³ Spencer-Lane (n 2) para 1-164.

⁹⁴ Cf, eg, Law Commission, *Adult Social Care: A Consultation Paper* (Law Com CP 192, 2010) Part 7 for discussion of residential care provided under National Assistance Act 1948, s 21.

⁹⁵ Social Care Institute for Excellence, *Fair Access to Care Services (FACS): Prioritising Eligibility for Care and Support* (2013); see, eg, Law Commission (n 94) paras [6.5]-[6.18]; *R (McDonald) v Kensington and Chelsea Royal London Borough Council* [2011] UKSC 33 [8] (Lord Brown).

During the consultation exercise on the draft regulations, however, '[a] majority of [LAs] felt the...regulations would make more people eligible than is currently the case, and thus increase costs'.⁹⁶ The requirement for two or more relevant 'inabilities' (discussed immediately below) was apparently added to the regulations after the consultation, and empirical evidence suggests that the Government has been essentially successful in its replication aims.⁹⁷

In order to fall within the national eligibility threshold, there are three cumulative conditions in the Regulations.⁹⁸ The first is that the adult's needs arise from or are related to a physical or mental impairment or illness. Rather mysteriously, the new guidance specifies that the LA must be satisfied that the needs are not caused by 'other circumstantial factors',⁹⁹ while providing that a formal diagnosis should be unnecessary. Perhaps the reference to such factors excludes needs generated by excessive working hours or similar. Spencer-Lane feared that the original wording '*due to a physical or mental impairment or illness*' (emphasis added) imported a medical test, risked excluding drug and alcohol addicts, and contradicted the Law Commission's view that there should be no medical-legal categorisation.¹⁰⁰ But the final wording may be looser.

The second requirement is that as a result of the needs, the adult is unable to achieve two or more specified outcomes. This effectively imposes a *de minimis* threshold that might be useful, and few people with real need would be unable to achieve only one of the outcomes in the relevant sense. But the multiplicity requirement undermines the importance of each individual outcome. An inability for the purposes of the Regulations means¹⁰¹ that the adult is unable to achieve the

⁹⁶ Department of Health (n 28) 20.

⁹⁷ J-L Fernández, T Snell and J Marczak, *An Assessment of the Impact of the Care Act 2014 Eligibility Regulations* (PSSRU Discussion Paper DP2905, 2015).

⁹⁸ CSECR, r 2; Department of Health (n 29) paras 6.103-6.104.

⁹⁹ Department of Health (n 29) para 6.105

¹⁰⁰ Spencer-Lane (n 2) para 1-166; Law Commission (n 7) para 12.33.

¹⁰¹ CSECR, r 2(3).

outcome without assistance, can do so only in a manner causing ‘significant pain, distress or anxiety’, in one that ‘endangers or is likely to endanger the health or safety of the adult, or...others’ or in one that ‘takes significantly longer than would normally be expected’. The relevant outcomes are set out in the Regulations. The guidance seems to suggest that this is done non-exhaustively,¹⁰² but that is not clear from the text of the Regulations. The list is: managing and maintaining nutrition, maintaining personal hygiene, being appropriately clothed, developing and maintaining family/other personal relationships, being able to make use of the home safely, maintaining a habitable home environment, accessing and engaging in work, training, education or volunteering, ‘making use of necessary facilities or services...including public transport, and recreational facilities or services’, and carrying out caring responsibilities for a child.¹⁰³ There is no hierarchy of needs or aspects of well-being in the Act or Regulations.¹⁰⁴ Where needs fluctuate, ‘the [LA] must take into account the adult’s circumstances over such period as it considers necessary to establish accurately the...level of need’.¹⁰⁵

The final requirement for eligibility is that as a result of being unable to achieve the outcomes, there is, or is likely to be, a significant impact on the adult’s well-being,¹⁰⁶ as defined within the well-being principle.¹⁰⁷ The LA will examine the cumulative effect of being unable to perform the relevant tasks. ‘Significant’ is left undefined in the Regulations, but ‘well-being’ seems to be at least partially subjective.¹⁰⁸

¹⁰² Department of Health (n 29) para 6.107.

¹⁰³ CSECR, r 2(2).

¹⁰⁴ Department of Health (n 29) para 6.118.

¹⁰⁵ CSECR, r 2(4).

¹⁰⁶ CSECR, r 2(1)(c).

¹⁰⁷ Department of Health (n 29) para 6.108.

¹⁰⁸ *ibid* para 6.111.

When making an eligibility determination, the LA must do so without taking account of the fact that needs are being met by an informal carer.¹⁰⁹ The Act creates ‘the first ever entitlement to support for carers’,¹¹⁰ and the Impact Assessment expects this to be the main cost of implementing Part 1.¹¹¹ Previously, there was no duty to provide services or apply an eligibility framework for carers,¹¹² and the Department of Health’s guidance on the matter was non-statutory.¹¹³ Carers’ own eligibility for care and support, which is independent to the eligibility of the care recipient, will also be governed by the Care and Support (Eligibility Criteria) Regulations. The criteria are in some respects similar to those applied to a care recipient,¹¹⁴ although carers are at a two-fold advantage. They face fewer formal hurdles in demonstrating eligible needs (albeit that the substantive criteria may be harder to satisfy in particular circumstances) and they are less likely to be charged for support services. But this reflects the fact that, as the Government recognizes,¹¹⁵ the LA may experience a net gain if it provides a service to a carer rather than providing caring services itself to the person whom the carer had previously been looking after. There are also circumstances in which a service providing respite for a carer will be charged to the adult who directly receives the service.¹¹⁶

When it has assessed an adult who appears to require care and support, an LA must meet eligible needs even where the adult’s assets exceed the threshold at which she would be expected to

¹⁰⁹ *ibid* para 6.119.

¹¹⁰ Department of Health (n 39) 1.

¹¹¹ Department of Health, (n 91) 2.

¹¹² Cf Carers (Recognition and Services) Act 1995; Carers and Disabled Children Act 2000; Carers (Equal Opportunities) Act 2004.

¹¹³ Spencer-Lane (n 2) para 1-250.

¹¹⁴ CSECR, r 3.

¹¹⁵ Department of Health (n 28) 9.

¹¹⁶ Department of Health (n 29) para 11.39.

fund her own care,¹¹⁷ although there currently remains an exception where the needs are to be met within a care home.¹¹⁸ The eventual right of ‘self-funders’¹¹⁹ to ask an LA to arrange care has been described as ‘important and groundbreaking’.¹²⁰ There are some exceptions to this section 18 duty, relating to the ordinary residence of the relevant person,¹²¹ the lack of a desire for the LA to meet needs expressed by a self-funder,¹²² or the existence of an informal carer who is meeting the needs,¹²³ or a person who is authorized or in a position to arrange care where the person lacks capacity.¹²⁴ But beyond that, Spencer-Lane is clear that section 18 imposes ‘a strong and enforceable duty that is owed to the individual’, such that if its criteria are met LA resources are irrelevant.¹²⁵

In spite of its general insistence that the Act largely replicates current practice, the Government has admitted that it ‘is critical to the successful implementation of the...Act that [LAs] are...able to plan effectively for the changes required, and that funds be made available to deliver those changes within a constrained financial environment’.¹²⁶ The Government tried to head off concerns that LAs would not be able to implement the reforms, or that there were problems with the new right of ‘self-funders’ (in the latter case arguing that the Act merely extended the right in

¹¹⁷ Care Act 2014, s.18; see also s 15 on the cap.

¹¹⁸ Care Act 2014 (Commencement No. 4) Order 2015/993, r 3; Department of Health (n 29) para 8.55.

¹¹⁹ See, generally, K Baxter and C Glendinning, *People who Fund their own Social Care* (School for Social Care Research 2014).

¹²⁰ Spencer-Lane (n 2) para 1-237.

¹²¹ Care Act 2014, s 18(1)(a); s 18(5)(a).

¹²² Care Act 2014, s 18(3)(b).

¹²³ Care Act 2014, s 18(7).

¹²⁴ Care Act 2014, s 18(4).

¹²⁵ Spencer-Lane (n 2) para 1-233.

¹²⁶ Department of Health (n 28) 5.

relation to non-residential care to cover residential care),¹²⁷ but it was later forced to delay the implementation of the new right relating to residential care until April 2020 alongside the cap.¹²⁸

As regards the care plan detailing how needs are to be met, the new focus away from merely providing services is relevant. The Government disagreed with the Law Commission's recommendation¹²⁹ that the content of the plan should be set out in regulations, preferring that a few high-level items be set out in the Act itself.¹³⁰ This may expand the ability to challenge the legal validity of such plans.¹³¹

There is much emphasis in the guidance on involvement of the adult concerned. But as Slasberg and Beresford highlight, the final say about what a person's needs are and how they should be met will remain with the LA,¹³² which is not necessarily consistent with a rights-based approach. The plan is subject to a 'reasonableness' standard¹³³ and, in something of a contrast to the duty to meet eligible needs, resource considerations are relevant to *how* needs are to be met,¹³⁴ even if the statutory guidance specifies that 'the [LA] should not set arbitrary upper limits on the costs it is willing to pay to meet needs'¹³⁵ and 'there should be no constraint on how the needs are met as long as this is reasonable'.¹³⁶

¹²⁷ *ibid* 7.

¹²⁸ Department of Health (n 6).

¹²⁹ Law Commission (n 7) Recommendation 32.

¹³⁰ Spencer-Lane (n 2) para 1-292. Section 27 of the Care Act and chapter 13 of Department of Health (n 29) deal with reviews of care plans.

¹³¹ Spencer-Lane (n 2) para 1-294.

¹³² Slasberg & Beresford (n 55) 1678.

¹³³ See, eg, Department of Health (n 29) para 10.31.

¹³⁴ See, eg, *R (KM) v Cambridgeshire* [2012] UKSC 23 under the pre-Act law.

¹³⁵ Department of Health (n 29) para 10.27.

¹³⁶ Department of Health (n 29) para 10.47.

The overall result of the Care Act's approach to social care, on Slasberg and Beresford's analysis, is 'a circular process...whereby "need" is defined by resource availability' even given doubts about the relevance of resources to the needs assessment,¹³⁷ with potential political advantages. It can certainly be said that the Act provides a clearer statutory footing for adult social care, but it is much less clear that this will have a significant impact on the nature and extent of care being provided in particular cases.

B. *Human Rights Arguments*

It is now necessary to turn to the compatibility of both the old and the new social care system with the ECHR, particularly as regards whether they provide(d) a sufficient standard of care to particular individuals. It must first be noted, however, that the use of the ECHR (ostensibly concerned with civil and political rights) to protect social and economic rights is controversial.¹³⁸ Resource issues are among the difficulties,¹³⁹ but King has suggested that '[i]f...interests are to ground social human rights claims and duties, then they must give rise to claims for resources required for a minimally decent life'.¹⁴⁰ Murphy argues that 'although the obvious sites for health rights...seem to be the European Social Charter system' (*inter alia* providing for rights to social and medical assistance monitored by a European Committee of Social Rights) and other mechanisms outside the ECHR itself, 'the [ECtHR] can claim to be a health-rights actor too',¹⁴¹ albeit that the case law is 'challenging' and the indirect protection of European Social Charter rights is for many either

¹³⁷ Slasberg and Beresford (n 55) 1679.

¹³⁸ See, eg P De Hert and M Eugenio, 'Specific Human Rights for Older Persons?' [2011] European Human Rights LR 398, 408-411.

¹³⁹ See, eg, Murphy (n 9) 117-123 for a general discussion of the financial costs of human rights.

¹⁴⁰ J King, *Judging Social Rights* (CUP 2012) 29.

¹⁴¹ Murphy (n 9) 47 (footnotes omitted).

‘unsatisfactory’ or ‘unappealing and unwelcome’.¹⁴² She still maintains that the case law (along with the actions of other bodies) ‘has disrupted an array of long-standing assumptions about health rights and...health rights justiciability’, such that ‘we can now have scrutiny and comparison vis-à-vis both...existing forms of justiciability and the effects of other rights...on health and health care’.¹⁴³

For its own part, the ECtHR has said that ‘the mere fact that an interpretation of the Convention may extend into the sphere of social and economic rights should not be a decisive factor against [that] interpretation’, and ‘there is no water-tight division separating that sphere from...civil and political rights’.¹⁴⁴ The most relevant Convention provision for present purposes is likely to be Article 8¹⁴⁵ and its protection of the ‘right to respect for private and family life’.¹⁴⁶ The ECtHR has held that ‘private life’ in Article 8 ‘is a broad concept which encompasses, inter alia, a person's physical and psychological integrity...; the right to “personal development”...; and the notion of personal autonomy’.¹⁴⁷

A public authority is nevertheless able to justify the limitation of an Article 8 right using Article 8(2) if it is done ‘in accordance with the law’ and is ‘necessary in a democratic society’

¹⁴² *ibid* 48.

¹⁴³ *ibid*; cf A Cahill-Ripley, ‘Thérèse Murphy, *Health and Human Rights*, Hart, 2013, Hardback, 258 pp., £45, 9781841138046’ (2014) 22 *Medical LR* 649, 653.

¹⁴⁴ *Budina v Russia* App no 45603/05 (ECtHR, 18 June 2009), 5 of transcript.

¹⁴⁵ That said, the ECtHR has recognized that ‘a wholly insufficient amount of pension and social benefits may raise an issue under Article 3 of the Convention’, which protects the right not to be ‘subjected to torture or to inhuman or degrading treatment or punishment’ (*Budina v Russia* (*ibid*)), and that ‘[i]t cannot be excluded that the acts and omissions of the authorities in the field of health care policy may in certain circumstances engage their responsibility under Article 2’, which protects the right to life (*Nitecki v Poland* App no 65653/01 (ECtHR, 21 March 2002) (Admissibility Decision) [1]).

¹⁴⁶ ECHR, Article 8(1).

¹⁴⁷ *McDonald v United Kingdom* (2015) 60 EHRR 1 [46].

inter alia ‘in the interests of...public safety or the economic well-being of the country...for the protection of health or morals, or for the protection of the rights and freedoms of others’.¹⁴⁸ The interference so justified must be a proportionate means of achieving the relevant legitimate aim,¹⁴⁹ although the state’s ‘margin of appreciation’ is wide ‘in issues of general policy, including social, economic and health-care policies’.¹⁵⁰

A useful contemporary example of judicial approaches to human rights in the context of adult social care, both domestically¹⁵¹ and in the ECtHR,¹⁵² is the case of Elaine McDonald. A severe stroke had limited Ms McDonald’s mobility, and she was unable safely to access a commode at night without the help of a carer. She also suffered from a small and neurogenic bladder, which caused a need to urinate two to three times per night. The necessary night-time carer had initially been provided by the LA on the basis that her need (assessed under section 47 of the National Health Service and Community Care Act 1990)¹⁵³ was for assistance to reach a commode, but it then proposed that she used incontinence pads and absorbent bedding (even though she was not incontinent), which would eliminate the need for the carer and save the authority around £22,000. She was informed of the decision to reduce her care *before* several reviews of her care plan, which effectively changed the assessment of her needs and concluded that the use of pads was a practical and appropriate solution. Ms McDonald understandably considered this proposal ‘an intolerable

¹⁴⁸ ECHR, Article 8(2).

¹⁴⁹ See, eg, *McDonald v United Kingdom* (2015) 60 EHRR 1 [50].

¹⁵⁰ *ibid* [54].

¹⁵¹ *R (on the application of McDonald) v Kensington and Chelsea Royal London Borough Council* [2009] EWHC 1582 (Admin); [2010] EWCA Civ 1109; [2011] UKSC 33. See, generally, Carr (n 11); H Carr, ‘Legal Technology in an Age of Austerity: Documentation, “Functional” Incontinence and the Problem of Dignity’ in D Cowan and D Wincott (eds), *Exploring the 'Legal' in Socio-Legal Studies* (Palgrave 2016).

¹⁵² *McDonald v United Kingdom* (2015) 60 EHRR 1. See, generally, Pritchard-Jones (n 12).

¹⁵³ See also the duties owed by LAs under Chronically Sick and Disabled Persons Act 1970, s 2(1).

affront to her dignity’,¹⁵⁴ but her claim of an Article 8 breach was dismissed entirely by a majority of the Supreme Court (alongside several other claims) and largely by the ECtHR.

In the Supreme Court decision in *McDonald*, Lord Brown (with whom Lords Dyson and Walker agreed and Lord Kerr agreed on Article 8) stated that ‘[t]here is no dispute that in principle [Article 8] can impose a positive obligation on a state...to provide support [or] that the provision of home-based community care falls within the scope of the article’,¹⁵⁵ provided Ms McDonald could establish ‘a direct and immediate link between the measures sought...and [her] private life’,¹⁵⁶ and ‘a special link between the situation complained of and the particular needs of [her] private life’.¹⁵⁷ Even if those links were present, however, Lord Brown emphasized the width of the margin of appreciation afforded by the Strasbourg court and rather dismissively described the ‘hopelessness’ of Ms McDonald’s case on Article 8.¹⁵⁸

A breach of Article 8 (but not Article 3)¹⁵⁹ had been found in the earlier case of *R (Bernard) v Enfield London Borough Council*, where it was noted that ‘those entitled to care under s.21 [of the National Assistance Act 1948] are a particularly vulnerable group’, and that Article 8 gave rise to duties in relation to such people to take ‘[p]ositive measures...(by way of community care facilities)’.¹⁶⁰ Sullivan J held that following its assessment the LA in *Bernard* ‘was under an obligation...to take positive steps, including the provision of suitably adapted accommodation, to enable the claimants and their children to lead as normal a family life as possible, bearing in mind

¹⁵⁴ [2011] UKSC 33 [1].

¹⁵⁵ [2011] UKSC 33 [15].

¹⁵⁶ [2011] UKSC 33 [15], citing *Botta v Italy* (1998) 26 EHRR 241 [34]-[35].

¹⁵⁷ [2011] UKSC 33 [15], citing *Sentges v Netherlands* (2003) 7 CCL Rep 400, 405.

¹⁵⁸ [2011] UKSC 33 [16].

¹⁵⁹ See n 145 above.

¹⁶⁰ [2002] EWHC 2282 (Admin) [32] (Sullivan J).

the second claimant's severe disabilities'.¹⁶¹ In failing to comply, it had 'condemned' the claimants to living conditions making it 'virtually impossible for them to have any meaningful private or family life'.¹⁶² The consequence of the difficulties caused was that the disabled wife often ended up urinating and defecating on the living room floor and could not play any real role in looking after the claimants' children. Lord Brown, however, described the 'striking...contrast between' *Bernard* and the *McDonald* case before him.¹⁶³ Moreover, in *Anufrijeva v Southwark London Borough Council*,¹⁶⁴ which he described as '[t]he leading domestic case on the positive obligation to provide welfare support under article 8',¹⁶⁵ the Court of Appeal had somewhat implausibly held that an individual is unlikely to require welfare support under Article 8 unless his predicament engages Article 3 (which confers an absolute right but carries a 'high threshold'),¹⁶⁶ although it accepted that matters may differ where there are children and/or a family unit involved.

In dismissing Ms McDonald's claim, Lord Brown emphasized that the LA 'went to great lengths...to consult the appellant and [her partner] about [her] needs and the possible ways of meeting them'.¹⁶⁷ On his analysis, the authority 'sought to respect as far as possible her personal feelings and desires, at the same time taking account of her safety, her independence and their own responsibilities towards all their other clients', and 'respected [her] human dignity and autonomy, allowing her to choose the details of her care package within their overall assessment of her needs'.¹⁶⁸ He held that the claimant's Article 8(1) rights had not even been interfered with, so that

¹⁶¹ [2002] EWHC 2282 (Admin) [33].

¹⁶² [2002] EWHC 2282 (Admin) [34].

¹⁶³ [2011] UKSC 33 [17].

¹⁶⁴ [2003] EWCA Civ 1406.

¹⁶⁵ [2011] UKSC 33 [18].

¹⁶⁶ See, eg, *Budina v Russia* App no. 45603/05 (ECtHR, 18 June 2009) 7 of transcript.

¹⁶⁷ [2011] UKSC 33 [19].

¹⁶⁸ [2011] UKSC 33 [19].

there was no need to justify the decision under Article 8(2), except for the period where the care provided was not in accordance with its own care plan.¹⁶⁹

Baroness Hale undertook a strong dissent in the Supreme Court. While she did not apparently address the Article 8 point directly, she clearly had it in mind and opined that ‘the need for help to get to the lavatory or commode is so different from the need for protection from uncontrollable bodily functions, that it is irrational to confuse the two’,¹⁷⁰ and suggested that the LA had failed to respect Ms McDonald’s dignity.¹⁷¹

Although aspects of Baroness Hale’s judgment in *McDonald* drew unusually strong criticism from members of the majority in the Supreme Court,¹⁷² the ECtHR agreed with her implication that human dignity was engaged in a relevant sense and did not ‘exclude that the particular measure complained of by the applicant...was capable of having an impact on her enjoyment of her right to respect for private life’, finding that ‘the contested measure reducing the level of her healthcare [sic] falls within the scope of art 8’.¹⁷³ It was ‘prepared to approach the...case as...involving an interference with the...right to respect for...private life, without entering into the question whether...art 8(1) imposes a positive obligation on...states to put in place a[n equivalent] level of entitlement’.¹⁷⁴

In *R (on the application of Condliff) v North Staffordshire Primary Care Trust*, however, consistently with Lord Brown’s analysis in *McDonald*, Toulson LJ had noted that the ECtHR ‘has

¹⁶⁹ The Court of Appeal had already found this to be a (limited) breach of statutory duty: [2010] EWCA Civ 1109.

¹⁷⁰ [2011] UKSC 33 [75].

¹⁷¹ See *R (A) v East Sussex County Council* [2003] EWHC 167 (Admin) [86]-[98] for Munby J’s useful analysis of the dignity-related aspects of Article 8; see also *Pretty v United Kingdom* [2002] 2 FLR 45.

¹⁷² See, eg, [2011] UKSC 33 [32] (Lord Walker), with whom Lord Dyson expressly agreed ([56]). See Carr (n 11) for discussion.

¹⁷³ (2015) 60 EHRR 1 [47].

¹⁷⁴ *ibid* [49].

been particularly wary of attempts to establish a positive obligation under article 8 in the area of...state benefits, because questions about how much money should be allocated...on competing areas of public expenditure, and how the sums allocated to each area should be applied,...essentially...lie in the political domain'.¹⁷⁵ Toulson LJ claimed that 'there is no reported case in which the court has upheld...a claim by an individual complaining of the state's non-provision of medical treatment'.¹⁷⁶ In *Sentges v Netherlands*, for example, the ECtHR held that '[i]n view of their familiarity with the demands made on the health care system as well as with the funds available to meet [them],...national authorities are in a better position to carry out [the relevant] assessment than an international court'.¹⁷⁷

This trend is demonstrated by the ECtHR's conclusion in *McDonald*.¹⁷⁸ Despite the potential *prima facie* breach of Article 8(1), it accepted that 'the interference pursued a legitimate aim, namely the economic well-being of the state and the interests of...other care-users'.¹⁷⁹ It then considered whether 'the decision not to provide...a night-time carer...was 'necessary in a democratic society'...and...proportionate to the legitimate aim'.¹⁸⁰ It concluded that both of those criteria were met having regard to the wide margin of appreciation, and was 'satisfied that the national courts adequately balanced the applicant's personal interests against the more general interest of the...[LA] in carrying out its social responsibility' of care provision 'to the community at large'.¹⁸¹ The complaint in relation to the period after the care plan review was therefore manifestly ill-founded.

¹⁷⁵ [2011] EWCA Civ 910 [40].

¹⁷⁶ [2011] EWCA Civ 910 [41].

¹⁷⁷ App no 27677/02, (ECtHR, 8 July 2003) 7 of transcript.

¹⁷⁸ (2015) 60 EHRR 1.

¹⁷⁹ *ibid* [53].

¹⁸⁰ *ibid*.

¹⁸¹ *ibid* [57].

The ECtHR did find a breach of Article 8 as regards the period before the review, since then the LA was failing to provide care consistently with its own original assessment of needs. That was not ‘in accordance with the law’ for the purposes of Article 8(2),¹⁸² and the Court awarded €1,000 in respect of non-pecuniary damage.¹⁸³ This conclusion, however, is consistent with Slasberg and Beresford’s suggestion that an LA need only modify its assessment of need to control the extent of its obligations.¹⁸⁴

Analysing the Supreme Court’s decision in *McDonald*, Carr opines that ‘the increasing reach of the [ECHR], in particular the potential ambit of Article 8, together with a recently implemented statutory framework designed to address discrimination and inequalities,^[185] opened up new legal possibilities to the Court, so there was some potential to address popular concern about adult social care’.¹⁸⁶ She notes, however, that ‘[t]he legal reasoning of the majority demonstrated resistance to taking advantage of those opportunities’.¹⁸⁷ Pritchard-Jones draws a similar conclusion about the ECtHR proceedings.¹⁸⁸ It is particularly troubling that the majority of the Supreme Court were less willing to engage with Article 8 than the ECtHR even though the former were untrammelled by the difficulties of being a supranational court.

¹⁸² *ibid* [51]-[52].

¹⁸³ *ibid* [63].

¹⁸⁴ Spencer-Lane illustrates the confusion about the distinction between assessing needs and eligibility using *McDonald* as regards the original needs assessment: Spencer-Lane (n 2) para 1-100.

¹⁸⁵ Carr is apparently referring to the Equality Act 2010.

¹⁸⁶ Carr (n 11) 223.

¹⁸⁷ *ibid*.

¹⁸⁸ Pritchard-Jones (n 12) 110.

Clough and Brazier highlight the focus in the jurisprudence on procedural factors in the allocation of resources rather than the substantive scope of such decisions.¹⁸⁹ That is evident in *McDonald* given the LA's ability to render its actions compliant with the ECHR by reviewing Ms McDonald's care plan in consultation with her and her partner.¹⁹⁰ Clough and Brazier link the Care Act's well-being principle to the protection of human rights.¹⁹¹ That said, they also acknowledge the limitations of simply stating human rights, advocating a more relational and contextual approach,¹⁹² and it could be argued that the somewhat paternalistic concept of well-being sits uneasily with that of rights.

For the moment, the utility of the ECHR in measuring or ensuring the adequacy of care provision under either the old or the new law is limited, and it would be unrealistic to suggest that a *McDonald*-like situation would be prevented by the Care Act. On O'Conneide's analysis, 'when it comes to the substance of [resource allocation] decisions, in respect of which public authorities enjoy wide discretion, Convention rights have little, if any, purchase, and courts will only strike down a decision if it meets' the standard of irrationality usually applied in judicial review¹⁹³ cases.¹⁹⁴ This means that, '[i]n general, legal accountability mechanisms play a very limited role when it comes to resource allocation decisions that raise substantive issues of social justice',¹⁹⁵ which severely limits the utility of human rights norms in the area of social care.

¹⁸⁹ See, generally, B Clough and M Brazier, 'Never too Old for Health and Human Rights?' (2014) 14 *Medical Law International* 133; see also, eg, Herring (n 7) 146-47.

¹⁹⁰ See also, eg, *Watts v United Kingdom* (2010) 51 EHRR SE5.

¹⁹¹ Clough and Brazier (n 189) 145.

¹⁹² *ibid* 146ff.

¹⁹³ See, generally, HWR Wade and CF Forsyth, *Administrative Law*, 11th edn (OUP 2014).

¹⁹⁴ C O'Conneide, 'Legal Accountability and Social Justice' in N Bamforth and P Leyland (eds), *Accountability in the Contemporary Constitution* (OUP 2014) 394.

¹⁹⁵ *ibid*.

The next section of the article specifically considers the funding of social care under the Care Act, before considering its implications from a policy and human rights perspective within that realm.

3. The Funding of Social Care

A. The Care Act's Reforms

The funding of social care is a contentious issue, and one purpose of the Care Act is to reduce the controversy and the burden surrounding it for care recipients. It is significant, however, that no funding reform clauses were included in the draft Care and Support Bill.¹⁹⁶

The charging regimes for health care and social care have been separate since the beginnings of the NHS,¹⁹⁷ although there has been a 'progressive withdrawal of the [NHS] from the provision of illness-associated care'.¹⁹⁸ The National Health Service Act 2006 mandates that '[t]he services provided as part of the health service in England must be free of charge' except where legislation expressly provides otherwise.¹⁹⁹ By contrast, however, the Dilnot Commission on the Funding of Care and Support explained that '[v]ery broadly, under [the pre-Act social care] system, people with assets over £23,250 receive no financial state support and need to fund their own care' and '[t]he level and type of state support for people with assets below this threshold depends on

¹⁹⁶ HM Government, *Draft Care and Support Bill* (Cm 8386, 2012); Spencer-Lane (n 2) para A1-012.

¹⁹⁷ K Bilton, 'Care Arrangements: Who Cares? Who Pays?' (2014) 1 Bulletin of the Social Work History Network 14, 14.

¹⁹⁸ *ibid* 18.

¹⁹⁹ National Health Service Act 2006, s 1(4).

their needs and income'.²⁰⁰ It is also significant that, unlike the NHS budget, the adult social care budget is not ring-fenced.²⁰¹

The starkness of the funding differences is not, however, reflected in the distinction between the types of care, which has been discussed in the previous section of the article. Spencer-Lane points to an example whereby health and social care can be provided by the same piece of equipment, which could create a funding problem.²⁰² There is also controversy over NHS Continuing Healthcare, 'a package of ongoing care...arranged and funded solely by the [NHS] for individuals outside a hospital setting who have complex ongoing healthcare needs, of a type or quantity such that they...have a "primary health need"...as a result of disability, accident or illness'.²⁰³ The King's Fund describe NHS Continuing Healthcare as involving an 'all or nothing' assessment, whereby those who pass it receive free care and accommodation,²⁰⁴ but the Government rejected the suggestion that the power in what is now section 13(7) should be exercised to clarify the boundary between eligibility for LA-funded care and NHS-funded continuing healthcare.²⁰⁵

Mayhew and Smith emphasize that '[a]...system for funding social care...along similar lines to the NHS...would involve a combination of higher taxes, more borrowing and/or redirecting public finances from other priority areas',²⁰⁶ at a time of a perceived need for austerity and in which

²⁰⁰ Commission on Funding of Care and Support (n 8) 11.

²⁰¹ Spencer-Lane (n 2) para 1-039.

²⁰² Spencer-Lane (n 2) para 1-268.

²⁰³ Department of Health (n 29) para 15.33. See National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations SI 2012/2996, Part 6.

²⁰⁴ King's Fund, *A New Settlement for Health and Social Care: Final Report* (2014) 3.

²⁰⁵ Spencer-Lane (n 2) para 1-149.

²⁰⁶ L Mayhew and D Smith, 'Personal Care Savings Bonds: A New Way of Saving Towards Social Care in Later Life' (2014) 39 *Geneva Papers* 668, 670-71.

LAs are already struggling to meet demands. Even so, the King's Fund assert that pressures in health and social care and the needs of an ageing population 'call for a response that goes well beyond patching up existing services and making the changes set out in the Dilnot report'.²⁰⁷ They make the bold claim that 'higher public spending on health and social care is affordable if it is phased in over a decade' and recommend that it be funded 'through tax and national insurance increases, reallocating funds from other areas of spending, and changes to prescription charges'.²⁰⁸ For the time being, however, the marked distinction between the funding arrangements for health and social care looks set to stay. It is notable that the relevant Minister in the House of Commons expressed a determination to achieve free social care at the end of life, which could be provided for by regulation, but refused to commit the Government.²⁰⁹ One's view on such matters will depend upon one's position on the political spectrum, even if there must surely come a point where the need to protect human dignity transcends political and other differences.²¹⁰

The charging and funding regime in the Care Act is nevertheless 'intended to make charging fairer and more clearly understood by everyone'.²¹¹ Hopkins and Laurie describe it as 'a significant rebalancing of the individual-state relationship in terms of responsibility for funding...social care, whilst maintaining the underlying model of funding through both individual and state contributions'.²¹² Many of the relevant principles are set out in the Care and Support (Charging and Assessment of Resources) Regulations,²¹³ although the cap was the subject of a second consultation

²⁰⁷ King's Fund (n 204) vi.

²⁰⁸ *ibid.*

²⁰⁹ Spencer-Lane (n 2) para 1-248.

²¹⁰ See, generally, H Meenan, N Rees and I Doron, *Towards Human Rights in Residential Care for Older Persons International Perspectives* (Routledge 2016).

²¹¹ Department of Health (n 29) para 8.2.

²¹² Hopkins and Laurie (n 4) 112.

²¹³ SI 2014/2672 ('CS(CAR)R').

ending several months before the delay in its implementation was announced, and those Regulations would need to be amended and supplemented before it could be introduced.²¹⁴

Under the regime that would be introduced by via the Care Act, based somewhat on the Dilnot Commission's proposals but also delayed by the Government until 2020, people with assets of £118,000 (where the person's home is included in the financial assessment; the figure is £27,000 otherwise)²¹⁵ will start to receive help with care costs if they need to go into a care home.²¹⁶ £17,000 would have been the new lower limit of the means test below which no contribution will be expected from the individual,²¹⁷ increased from £14,250.²¹⁸

It has been seen that the LA's obligation to assess needs applies irrespective of the adult's resources, and that the needs assessment will begin progress towards the new cap on lifetime care costs that an individual will have to bear. The cap was a central aspect of the Dilnot proposals and the Act.²¹⁹ It was expected to be £72,000 for those developing eligible care needs after the age of 25 if it was first introduced in April 2016,²²⁰ and it will be adjusted annually to account for inflation.²²¹ The Act places an LA under a duty to keep a 'care account' to measure progress towards the cap.²²² A 'personal budget' *per se*²²³ is necessary where an LA is meeting needs.²²⁴ It is a mechanism by

²¹⁴ Department of Health, *The Care Act 2014: Consultation on Draft Regulations and Guidance to Implement the Cap on Care Costs and Policy Proposals for a New Appeals System for Care and Support* (2015).

²¹⁵ *ibid* para 9.7.

²¹⁶ *ibid*.

²¹⁷ *ibid* para 9.8.

²¹⁸ National Assistance (Assessment of Resources) Regulations SI 1992/2977, r 28(1).

²¹⁹ Care Act 2014, s 15.

²²⁰ Department of Health (n **214**) para 10.2.

²²¹ Care Act 2014, s 16.

²²² Care Act 2014, s 29.

²²³ Care Act 2014, s 26.

²²⁴ Department of Health (n **29**) para 11-7.

which an individual can control the purchasing of care services..., which ‘can be taken...as a direct (cash) payment; as an account held and managed by the [relevant] council in line with the individual’s wishes;...as an account placed with a third party...and called off by the individual; or as a mixture of these’.²²⁵ The statutory guidance states that ‘[t]he personal budget must always be an amount sufficient to meet the person’s care and support needs, and must include the cost to the LA of meeting the person’s needs’.²²⁶ An ‘independent personal budget’²²⁷ will keep track of progress where an adult has eligible needs that the LA is not meeting.²²⁸ Relative progress towards the cap will be maintained after the annual adjustment.²²⁹ It is also significant that the LA’s own contributions towards the person’s care will count towards the cap, meaning that people within the means test will face a lower cap.²³⁰ The cap system has been criticized for being too complex for LAs to administer, given the tracking involved,²³¹ though a proposal to focus on time receiving care at a substantial level rather than cost was rejected.²³²

There is an obligation to carry out a full financial assessment where an LA identifies needs meeting the eligibility criteria and thinks that it would charge for meeting them,²³³ except where a light-touch assessment is appropriate or the adult is not co-operating.²³⁴ There must be regular

²²⁵ HM Government, *Caring for our Future: Reforming Care and Support* (Cm 8378, 2012) 15 fn 22.

²²⁶ Department of Health (n 29) para 11-10.

²²⁷ Care Act 2014, s 29.

²²⁸ Spencer-Lane (n 2) para 1-331.

²²⁹ Care Act 2014, s 16(2).

²³⁰ Spencer-Lane (n 2) para 1-206; Department of Health (n 214) para 3.12.

²³¹ HL Deb 16 July 2013, vol 74, col 698.

²³² Spencer-Lane (n 2) para 1-203.

²³³ Care Act 2014, s 17(1)-(2).

²³⁴ CS(CAR)R, r 10; Department of Health (n 29) paras 8.22-8.26.

Final Version to be published in (2016) 38(2) Oxford Journal of Legal Studies.

reassessment of an adult's ability to pay.²³⁵ It should be noted that each person must be assessed individually.²³⁶ Capital and income can be taken into account²³⁷ (except where disregarded), although the border between them is not watertight and the thresholds are based on capital.²³⁸ There is an obligation to charge only when capital limits are exceeded in the context of care homes,²³⁹ although the Impact Assessment suggests that this will be removed and replaced with a discretion if the funding reforms come fully into effect.²⁴⁰ Local authorities will have quite some discretion concerning disregards, maximum charges etc., but the guidance urges them to exercise it consistently with reference to a developed policy.²⁴¹ The Regulations appear similar to the old National Assistance (Assessment of Resources) Regulations.²⁴² But it is significant and arguably beneficial to the rule of law and accessibility that non-residential care is also now subject to regulations rather than mere guidance, and the Impact Assessment notes that the Government has taken the 'opportunity to make some minor adjustments' even if those changes 'are designed to be cost neutral'.²⁴³

²³⁵ This will usually be annual but should also occur on a change in circumstances or if she requests it: Department of Health (n **29**) paras 8.16-8.17.

²³⁶ *ibid* para 8.8.

²³⁷ Care Act 2014, s 17(11).

²³⁸ Department of Health (n **29**) Annex B, paras 55-57.

²³⁹ CS(CAR)R, r 12(2).

²⁴⁰ Department of Health (n **91**) para 1.116.

²⁴¹ Department of Health (n **29**) paras 8.43-8.48.

²⁴² Department of Health, 'Charging for Care and Support' <<http://careandsupportregs.dh.gov.uk/category/charging/>> accessed 20 February 2016. See, generally, D Coldrick, L Bradley and A Thornton, *Coldrick on Care Home Fees*, 2nd edn (Ark Group, 2012).

²⁴³ Department of Health (n **91**) para 1.113; see also *Walford v Worcestershire County Council* [2015] EWCA Civ 22 [17] (Underhill LJ).

The Regulations and guidance do not define ‘capital’ exhaustively, but the term generally ‘refers to financial resources available for use and tends to be from sources...more durable than money in the sense that they can generate a return’.²⁴⁴ The value of capital is reduced to account for selling expenses, and by the amount of outstanding debts secured on the asset.²⁴⁵ Capital that is not immediately realisable is still included.²⁴⁶ A person is assessed on the basis of her actual and notional capital, which includes capital that would be available to the person if she applied for it, is paid to a third party in respect of a person, or the person has deliberately deprived herself of it to reduce liability.²⁴⁷ The value of notional capital is reduced by the difference between the weekly amount the person pays and the amount she would pay if the notional capital did not apply.

A number of assets are disregarded for the purposes of assessing capital.²⁴⁸ Outside a care home context, assessment must exclude the adult’s main or only home.²⁴⁹ Even if the person *is* in a care home, there is a disregard if the person is there temporarily and intends to return to the main home or is taking reasonable steps to dispose of it, or the main home is occupied by a non-estranged partner, a single parent who is an estranged partner, a relative aged 60 or over or under 18, or who is incapacitated.²⁵⁰ There is a discretion to disregard the home in other circumstances, including where a relative moves into the property *after* the adult moves into a care home,²⁵¹ but it should be

²⁴⁴ Department of Health (n 29) Annex B, para 5.

²⁴⁵ CS(CAR)R, r 20; Department of Health (n 91) Annex B para 14.

²⁴⁶ *ibid* Annex B, para 23.

²⁴⁷ CS(CR)R, r 22. See further B Sloan, ‘Trusts and Anti-Avoidance under the Care Act 2014’ [2015] *Conveyancer and Property Lawyer* 489.

²⁴⁸ CS(CR)R, r 18(2); sch 2. Department of Health (n 91) Annex B, para 33.

²⁴⁹ CS(CAR)R, sch 2, para 4; Department of Health (n 29) para 8.43.

²⁵⁰ CS(CAR)R, sch 2, paras 1-8; Department of Health (n 29) Annex B, para 34.

²⁵¹ CS(CAR)R, sch 2, para 4(2); Department of Health (n 29) Annex B, paras 42-44.

noted that several categories of relative (who may be informal carers) are put at risk of losing their home by the social care system.

There is also a 12-week disregard of the value of a property when the adult first enters a care home or another disregard ends unexpectedly because a qualifying relative dies or goes into a care home himself.²⁵² There is a *discretion* in relation to other unexpected changes of circumstance.²⁵³ There are also additional temporary disregards in relation to certain types of property.²⁵⁴

Where a person has relevant assets between the lower and upper limit, the LA assumes that for every £250 of capital (or part thereof), the person can contribute £1 per week towards care costs. This is known as ‘tariff income’.²⁵⁵

As regards income, it is significant that income from current employment²⁵⁶ and self-employment is disregarded, and that these are widely interpreted.²⁵⁷ Most income from annuities,²⁵⁸ insurance²⁵⁹ and benefits are included, but direct payments, armed forces compensation payments and the mobility component of a Disability Living Allowance or Person Independence Payment are fully disregarded along with a number of other types of income.²⁶⁰ Notional income is treated in essentially the same way as notional capital.²⁶¹

²⁵² CS(CAR)R, sch 2 para.4(3).

²⁵³ Department of Health (n 29) Annex B, paras 45-46.

²⁵⁴ CS(CAR)R, sch 2; Department of Health (n 29) Annex B, para 47.

²⁵⁵ CS(CAR)R, r 25; Department of Health (n 29) Annex B, para 27.

²⁵⁶ Department of Health (n 29) para 8.21.

²⁵⁷ CS(CAR)R, r 14; Department of Health (n 29) Annex C, paras 8-9 but cf para 10. See, generally, CS(CAR)R, sch 1.

²⁵⁸ Department of Health (n 29) Annex C, paras 18-19.

²⁵⁹ *ibid* Annex C, para 26.

²⁶⁰ *ibid* Annex C.

²⁶¹ CS(CAR)R, r 17; Department of Health (n 29) Annex C, paras 32-35.

There is also a binding ‘personal expenses allowance’ for someone in a care home that is disregarded.²⁶² Outside a care home, a similar function is performed by the ‘minimum income guarantee’, which is set at the level of income support plus 25%.²⁶³ Where a person receives disability-related benefits, LAs are also advised to ensure that charging arrangements enable her to meet non-eligible needs.²⁶⁴

Even before the full details of the new system were published and its full implementation was delayed, the King’s Fund emphasized that only the cost of meeting *eligible* needs would count towards the cap, which (as explained above) are likely to be critical or substantial and not low or moderate.²⁶⁵ There is also concern that personal budgets (and therefore progress towards the cap)²⁶⁶ could be set below what it costs *an individual* to pay for care²⁶⁷ because the LA could secure cheaper provision itself.²⁶⁸ It should also be emphasized that the cap would exclude so-called ‘general’ or ‘daily’ ‘living costs’ within a care home, and these were expected to be set at around £12,000 per year.²⁶⁹ These limitations on the cap would have left many people paying a considerable sum towards their care even if the cap were brought into effect.²⁷⁰ For example, the

²⁶² CS(CAR)R, r 6; Department of Health (n 29) para 8.35.

²⁶³ CS(CAR)R, r 7; Department of Health (n 29) para 8.42.

²⁶⁴ Department of Health (n 29) para 8.42.

²⁶⁵ King’s Fund (n 204) 3.

²⁶⁶ Bilton (n 197).

²⁶⁷ Department of Health (n 214) ch 4.

²⁶⁸ Spencer-Lane (n 2) para 1-317.

²⁶⁹ Department of Health (n 214) para 7.3. See also J-L Fernández and P Nadash, ‘The Long-term Care Financing Problem’ in C Gori *et al* (eds), *Long-term Care Reforms in OECD Countries: Successes and Failures* (Policy Press, 2016) 32.

²⁷⁰ Institute and Faculty of Actuaries, *How Financial Products Can Work Alongside the Care Act 2014 to Help People Pay for Care: An Overview* (2015) 30

Institute and Faculty of Actuaries has estimated that the minority of car recipients who do reach the cap will have spent an average of £140,000 before doing so.²⁷¹

There are nevertheless some limits to LAs' charging ability. Reablement services or equipment and minor adaptations to the home cannot be charged for.²⁷² The LA cannot charge more than the service cost to provide, and cannot charge an administration fee, except in cases where a self-funder asks the LA to arrange the care and the fee represents actual costs incurred.²⁷³ Where an LA is charging an arrangement fee, this does not form part of the personal budget.²⁷⁴

Aside from the cap, a major area of funding reform within the Care Act relates to the offering of deferred payment agreements ('DPAs'), allowing the payment of social care costs to be deferred (via a secured loan) until a point such as the death of the care recipient or the sale of her home.²⁷⁵ Despite their opposition to the cap, Hopkins and Laurie support the new principle of 'universal deferred payment'.²⁷⁶ As well as retaining a discretion to offer them, LAs will be *prima facie* obliged to do so to an adult whose needs are to be met in a care home, who has no more than £23,250 in assets excluding the home and whose home is not disregarded.²⁷⁷ This is significant because of the concern that people could be forced to sell their homes during their own lifetimes in order to pay for their care, although some have questioned the idea that people have really been so

²⁷¹ Institute and Faculty of Actuaries, *How Pensions Can Help Meet Consumer Needs under the new Social Care Regime* (2014) 6.

²⁷² CS(CAR)R, r 3; Department of Health (n 29) para 8.14.

²⁷³ CS(CAR)R, r 5; Department of Health (n 29) para 8.15.

²⁷⁴ Department of Health (n 29) para 11.13.

²⁷⁵ The DPA *prima facie* falls due for repayment 90 days after the person's death or on disposal of property on which the LA has a charge: Department of Health (n 29) para 9.104; Care and Support (Deferred Payment) Regulations SI 2014/2671, r 7.

²⁷⁶ Hopkins and Laurie (n 7) 137.

²⁷⁷ Care and Support (Deferred Payment) Regulations, r 2.

‘forced’, and pointed to the possible advantages of doing so.²⁷⁸ In any case, Spencer-Lane notes several weaknesses in the old DPA scheme.²⁷⁹ There was no obligation on LAs to offer them, and the Impact Assessment for the Act reported a ‘wide variation in both the number of [DPAs] offered ...and...the eligibility conditions attached’, such that only around 4,000 people entered them each year.²⁸⁰ In addition, LAs were not able to charge interest until after the person died, and preferred to use their general debt recovery powers because those allowed a charge to be placed on the home without consent.²⁸¹

The Government reported that ‘[t]he majority of respondents were highly supportive of the overall intention to extend the deferred payments scheme’.²⁸² There are nevertheless still concerns that the asset threshold for the mandatory offering of a DPA (effectively £23,250 in the first instance) and the apparent likelihood that only people with slightly more than that would be offered one on a discretionary basis effectively prevent the scheme from being universal, although the asset threshold could change. The Impact Assessment confirms that ‘self-funders would not be eligible for a deferred payment if they had more than £23,500 [sic] in savings’.²⁸³ While it justifies this on the basis that ‘[a]nyone above this threshold could...afford to pay for a year of...care out of their savings, without having to draw on their housing wealth’,²⁸⁴ there remains a significant limitation.²⁸⁵ The Impact Assessment also makes clear that ‘[LAs] will be required to seek adequate

²⁷⁸ Spencer-Lane (n 2) para 1-383.

²⁷⁹ Spencer-Lane (n 2) para 1-381.

²⁸⁰ Department of Health (n 91) para 8.3.

²⁸¹ Spencer-Lane (n 2) para 1-381.

²⁸² Department of Health (n 28) 27.

²⁸³ Department of Health (n 91) para 8.11.

²⁸⁴ *ibid.*

²⁸⁵ Cf Hopkins and Laurie (n 4) 137-138.

security' for a DPA,²⁸⁶ and can refuse to enter an agreement with someone who meets the general mandatory criteria if they are unable to obtain a first charge over the person's property.²⁸⁷ The statutory guidance provides that the authority must also seek consent from anyone with a beneficial interest in the property.²⁸⁸ The guidance was amended *inter alia* to ensure that LAs 'signpost' people to independent financial advice (including regulated financial advice but where appropriate before taking out a DPA.²⁸⁹ The facilitation of access to independent financial advice is included within an LA's information and advice-related obligations under section 4 of the Act, though there are concerns that the advice-related duty is general and does not seek to ensure that advice is received and understood.²⁹⁰ LAs' powers to recover debts have at least been reformed with the aim of providing greater protection to individuals,²⁹¹ but a DPA remains potentially prejudicial to the heirs of care recipients.

The Government hoped that a market in insurance products would develop once the cap comes into effect, to help people pay for care.²⁹² The King's Fund, however, claims that there are 'no signs' that such a market will develop.²⁹³ Mayhew and Smith innovatively propose new

²⁸⁶ Department of Health (n 91) [8.46]; cf Hopkins and Laurie (n 4) 134.

²⁸⁷ Care and Support (Deferred Payment) Regulations, r 4; Department of Health (n 29) para 9.12; see also Department of Health (n 27) 29 but cf Department of Health (n 29) paras 9.62-9.63.

²⁸⁸ Department of Health (n 29) paras 9.58-9.61, but cf Care and Support (Deferred Payment) Regulations, r 4(1)(b).

²⁸⁹ Department of Health (n 28) 28; see Spencer-Lane (n 2) paras 1-047-1-048, but cf Care and Support (Deferred Payment) Regulations, r 4.

²⁹⁰ Spencer-Lane (n 2) para 1-046.

²⁹¹ Care Act 2014, s 69; Department of Health (n 29) Annex D. But see also the anti-avoidance provisions in section 70 of the Act, discussed in Sloan (n 247).

²⁹² Department of Health, *Review of Care Products – Key Messages* (2014).

²⁹³ King's Fund (n 204) vi.

Final Version to be published in (2016) 38(2) Oxford Journal of Legal Studies.

Personal Care Savings Bonds that can be purchased and saved into to pay for future care,²⁹⁴ expressing concern that ‘[i]f spending by the state and by the individual does not keep pace with need,...the quality and availability of care will suffer unless there are better mechanisms to help people support themselves’.²⁹⁵

Similarly, the House of Lords Select Committee on Public Service and Demographic Change noted that ‘[t]he proposals [now embodied in the Act etc.] are primarily concerned with redistributing the costs of care [and] do not bring extra funding into the system to tackle the current funding crisis,...or address the problem of expanding need in the coming decades’.²⁹⁶ Kelly fears that ‘[LAs] will acquire enhanced duties and responsibilities at the very time when they have been endeavouring to cope with...substantial reductions in their funding’ and ‘the means by which these radical reforms will be funded in the future is not yet final’.²⁹⁷ It has nevertheless been seen that the Government has sought to minimize the impact of the reforms in some respects. Conversely, £470 million was announced for 2015-16 to cover the specific implementation of new duties and also to prepare for the expected further reforms in 2016-17.²⁹⁸

The next sub-section considers human rights and policy arguments surrounding the Act’s funding reforms in greater depth.

²⁹⁴ Mayhew and Smith (n 206). Their proposal involves a combination of a tax-free lottery and a savings account similar to premium bonds.

²⁹⁵ *ibid* 670.

²⁹⁶ House of Lords Select Committee on Public Service and Demographic Change, *Report of Session 2012–13: Ready for Ageing?* (HL 2012-13, 140) para 194; see also T Burchardt, P Obolenskaya and P Vizard, *The Coalition’s Record on Adult Social Care: Policy, Spending and Outcomes 2010-2015*, ‘Social Policy in a Cold Climate’ Working Paper (Centre for Analysis of Social Exclusion 2015).

²⁹⁷ Kelly (n 19) 75. See, eg, J Forder and F Vadean, ‘Estimating Relative Needs: Formulae for New Forms of Social Care Support: Using an Extrapolation Method: Interim Working Paper’ (PSSRU Discussion Paper 2877, 2014) for discussion of the resource implications of the new provisions.

²⁹⁸ Department of Health (n 28) 5-6.

B. Human Rights and Policy Arguments

The ECHR protects the property interests of individuals via Article 1 of its First Protocol,²⁹⁹ although there is an overlap between funding and the Article 8 issues considered in the previous section of this article.³⁰⁰ Article 8's distinctive protection for the 'home' might also be relevant, but it is 'doubtful' for these purposes that the necessary link is present for the care recipient herself (as distinct from an informal carer living in the same home) without 'an intention to return to the home following a move into permanent *residential care*'.³⁰¹

In *R (Limbuela) v Secretary of State for the Home Department*, Lord Scott specifically said that '[t]he Convention does not require...states to have a national health scheme free at the point of need'.³⁰² This was consistent with *Pentiacova v Moldova*, where it was also held that the 'margin of appreciation' afforded to individual states when implementing the ECHR was particularly wide when 'issues involve an assessment of...priorities in the context of the allocation of limited State resources'.³⁰³ Nevertheless, the particular operation of the social care funding system in an individual case might still cause problems under the Convention.

²⁹⁹ See, eg, T Allen, 'Liberalism, Social Democracy and the Value of Property under the European Convention on Human Rights' (2010) 59 *International & Comparative Law Quarterly* 1055 for general discussion of the protection provided by Article 1 of the First Protocol; and K Gray, 'Land Law and Human Rights' in L Tee (ed), *Land Law: Issues, Debates, Policy* (Willan Publishing 2002) for a general discussion of the relationship between human rights and property law.

³⁰⁰ See, eg, *Pentiacova v Moldova* (2005) 40 EHRR SE23 (admissibility decision). But see Goymour's argument (A Goymour, 'Property and Housing' in D Hoffman, *The Impact of the UK Human Rights Act on Private Law* (CUP 2011)) that English property law generally complies with Article 8.

³⁰¹ *Hopkins and Laurie* (n 4) 137 (emphasis added).

³⁰² [2006] 1 AC 396 (HL) [69].

³⁰³ (2005) 40 EHRR SE23, 218.

Article 1 of Protocol 1 provides that ‘[e]very natural or legal person is entitled to the peaceful enjoyment of his possessions’, and that ‘[n]o one shall be deprived of his possessions except in the public interest and subject to the conditions provided for by law and...the general principles of international law’. It sets out, however, not ‘in any way’ to ‘impair the right of a State to enforce such laws as it deems necessary to control the use of property in accordance with the general interest or to secure the payment of taxes or other contributions...’.³⁰⁴ It is in several respects a difficult Article.³⁰⁵ Allen details the controversy surrounding the very inclusion of a right to property in the Convention,³⁰⁶ although in his view it does not ‘represent a radical departure from traditional principles’ or ‘present a serious challenge [to] the existing...laws on property’.³⁰⁷

The ECtHR summarized the judicially-developed principles on Article 1 of the First Protocol in *Grudić v Serbia*.³⁰⁸ It said that ‘[t]he first and most important requirement...is that any interference by a public authority with the peaceful enjoyment of possessions should be lawful’, and ‘pursue a legitimate aim ‘in the public interest’’.³⁰⁹ Lawfulness requires ‘the existence of and compliance with adequately accessible and sufficiently precise domestic legal provisions’.³¹⁰ The margin of appreciation is ‘wide’, and the legislature’s judgment as to what is “‘in the public interest” should be respected unless that judgment is manifestly without reasonable foundation’.³¹¹

³⁰⁴ It was confirmed in *Kjartan Ásmundsson v Iceland* (2005) 41 EHRR 42 [39] that ‘[t]he second and third rules, which are concerned with particular instances of interference with the right to peaceful enjoyment..., are to be construed in the light of the general principle laid down in the first rule’.

³⁰⁵ See, eg T Allen, *Property and the Human Rights Act 1998* (Hart Publishing 2005) 8.

³⁰⁶ *ibid* ch 2.

³⁰⁷ *ibid* 17.

³⁰⁸ App no 31925/08 (ECtHR, 17 April 2012).

³⁰⁹ *ibid* [73].

³¹⁰ *ibid* [74].

³¹¹ *ibid* [75].

That said, '[a]ny interference must also be reasonably proportionate to the aim sought to be realized', meaning that 'a "fair balance" must be struck between the demands of the general interest of the community and...the protection of the individual's fundamental rights'.³¹² It has specifically been held that '[t]he requisite balance will not be found if the person or persons concerned have had to bear an individual and excessive burden'.³¹³ Allen notes that '[t]he legality principle is so easily satisfied that the doctrine of proportionality now performs some of the functions that might have been left to it'.³¹⁴

In *Marckx v Belgium*, Sir Gerald Fitzmaurice said in his dissenting opinion that the 'chief, if not the sole object of [Article 1] was to prevent the arbitrary seizures, confiscation, extortions, or other capricious interferences with peaceful possession'.³¹⁵ He also said that '[t]o metamorphose it into a vehicle for the conveyance of rights that go far beyond the notion of the peaceful enjoyment of possessions, even if they are connected with property, is to inflate it altogether beyond its true proportions'.³¹⁶ Nevertheless, Allen asserts that 'the desire to apply overarching principles relating to discrimination and legality...led the Court to...review laws imposing taxes [under Article 1], despite the conceptual distinctions between liabilities and property rights'.³¹⁷

The alleged violation of Article 1 of the First Protocol was not examined in detail in *Pentiacova v Moldova* because the applicants eventually decided not to pursue that complaint in relation to their haemodialysis. Relevantly to this article, the Article 1 argument was based on the fact that the applicants had been 'forced to spend their own money on their treatment and

³¹² *ibid* [76].

³¹³ *ibid* [76].

³¹⁴ Allen (n 305) 165.

³¹⁵ *Marckx v Belgium* (1979-80) 2 EHRR 330 [20].

³¹⁶ *ibid* [20].

³¹⁷ Allen (n 305) 33.

transportation’.³¹⁸ That said, in *Fratik v Slovakia*,³¹⁹ the ECtHR held that an obligation to contribute to a health fund and a pension fund was an interference with the right to peaceful enjoyment of possessions. It was also the case that ‘[a] financial liability arising out of the raising of taxes or contributions may adversely affect the guarantee...under Article 1...if it places an excessive burden on the person...concerned or fundamentally interferes with his [or] her... financial position’.³²⁰ This is significant, even though no such burden was found on the facts and the application was declared manifestly ill-founded.³²¹ Admittedly, however, in *James v UK* it was held that ‘[t]he taking of property in pursuance of a policy calculated to enhance social justice within the community can properly be described as being “in the public interest”’.³²² If it is possible to justify interferences with property in the general or public interest,³²³ it may be particularly difficult to argue that there has been a violation of Article 1 of the First Protocol 1 where property is appropriated to pay for a service intended for that person’s *own* benefit, whether under the old or the new social care system.

Domestically, it has been said that ‘dissatisfaction’ with the pre-Care Act funding situation ‘reached such a point that...governments have tacitly accepted an obligation to safeguard [offsprings’] hopes of inheritance’, albeit with ‘no actual “right to inherit”’.³²⁴ The Labour peer Lord Campbell-Savours was critical of this notion during the passage of the Care Bill, claiming that

³¹⁸ (2005) 40 EHRR SE23, 218.

³¹⁹ App no 51224/99 (ECtHR, 25 May 2004) (admissibility decision); 7 ITL Rep 173.

³²⁰ *ibid* 7 of transcript.

³²¹ Cf, eg, *Kjartan Ásmundsson v Iceland* (2005) 41 EHRR 42, where the total removal of a disability pension that affected a very small number of members, while the vast majority continued at their previous level of entitlement, was found to breach Article 1 of Protocol 1.

³²² *James v United Kingdom* (1986) 8 EHRR 123 [41].

³²³ See, eg, Allen (n 304) 129-30 for discussion.

³²⁴ Bilton (n 197) 18.

it would ‘simply transfer money from those without to those with’.³²⁵ Similarly, the legal scholars Hopkins and Laurie argue, with reference to theories of social citizenship and the social contract, that the 2014 Act (notwithstanding its current partially-implemented status) ‘reinforce[s] the expectation of leaving housing wealth as an inheritance which perpetuates inequalities across generations’, such that ‘the funding model provided by the Act is neither fair nor sustainable’.³²⁶ They point to research suggesting an increased willingness among the population to use housing wealth to fund lifestyle choices but not welfare, and criticize the Care Act as ‘a missed opportunity to alter attitudes towards the use of personal resources to fund social care’.³²⁷

In response to Lord Campbell-Savours, the Government claimed that ‘the vast majority of state support will be provided to the 40% of older people with the lowest income and wealth’.³²⁸ The King’s Fund make the point that only around half of social care expenditure occurs in respect of those over 65, and claim that the argument that a means testing system for social care is fair because the principal beneficiaries of any more generous system are inheritors would be considered unacceptable in the context of health care.³²⁹ It is also true that, as the present author has argued elsewhere,³³⁰ some of those who stand to benefit from the estates of social care recipients could be worthy informal carers who have suffered disadvantages and saved further expenditure and use of scarce resources, albeit that such people should theoretically benefit from the non-funding provisions of the 2014 Act.

From a human rights perspective, it seems unlikely that either the old or the new funding system would be held to violate Article 1 of the First Protocol, or indeed Article 8. It could be

³²⁵ HL Deb, 16 July 2013, vol 74, col 700.

³²⁶ Hopkins and Laurie (n 4) 113.

³²⁷ *ibid* 133.

³²⁸ HL Deb 16 July 2013, vol 74, col 710.

³²⁹ King’s Fund (n 204) 4.

³³⁰ B Sloan, *Informal Carers and Private Law* (Hart Publishing 2013).

argued, however, that the Care Act will make a breach even less likely if fully implemented. The Act has made the law more accessible and precise, which has been identified as important for the purposes of Article 1.³³¹ It is also in principle possible that the enormous charges that might currently be imposed on an individual with a high level of need and significant available resources could have been regarded as an ‘individual and excessive burden’ in the context of a system where those with fewer needs and/or fewer resources are charged less. It appears that, under the current system, some people are at risk of losing up to 80% of their assets in paying for care.³³² The cap on care costs, whatever its difficulties, would make the possibility of an arguable ‘individual and excessive burden’ less likely, as would the increased generosity of the means testing limits. Arguments based on inheritance, however, would always have been somewhat problematic for the purposes of the Convention, given that an inheritance is not a ‘possession’ for the purposes of Article 1 following *Marckx v Belgium*, although it was recognized that ‘the right to *dispose* of one's property constitutes a traditional and fundamental aspect of the right of property’.³³³ In any case, it could be argued that, following *Aston Cantlow Parochial Church Council v Wallbank*,³³⁴ an heir who ‘acquires’ a home subject to a social care charge acquires property that is already burdened (and in fact will not acquire a fully-fledged property right until the estate is duly administered),³³⁵ so that he cannot use Article 1 of the First Protocol because that would confer property-related rights that did not already exist.³³⁶

³³¹ See, generally, Allen (n 304) 96-100.

³³² Department of Health, *The Care Act 2014: Consultation on Draft Regulations and Guidance to Implement the Cap on Care Costs and Policy Proposals for a New Appeals System for Care and Support* (n 214) 4.

³³³ *Marckx v Belgium* (1979-80) 2 EHRR 330 [63].

³³⁴ [2003] UKHL 37.

³³⁵ *Re Leigh's Will Trusts* [1970] Ch 277.

³³⁶ Cf *JA Pye (Oxford) Ltd v United Kingdom* (2008) 46 EHRR 45; See, eg, *Goymour* (n 300) 277.

A litigant might attempt a discrimination-oriented argument based on Article 14 of the ECHR (which is not a standalone Article but requires that ‘enjoyment of the rights and freedoms set forth in [the ECHR]...be secured without discrimination on any ground such as sex [etc.]...or other status’) in conjunction with Article 1 of the First Protocol (or another Article), even if she cannot show that the substantive Article has been breached. Such an argument is made plausible by the irrelevance of individual resources to the NHS’s meeting of health-related needs and their high relevance to the social care provider’s doing so, in a manner that is apparently rarely found in other systems.³³⁷ Article 14 could also solve the problem with regard to inheritance identified above, as it did to some extent in *Marckx v Belgium* itself.³³⁸

Consistently with Herring’s argument on the boundary between health and social care,³³⁹ the King’s Fund opine that ‘it is simply not acceptable that people with conditions that can involve very similar burdens – cancer and advanced dementia, for example – end up making very different contributions to the cost of their care’.³⁴⁰ In spite of their argument that even the Care Act imposes too onerous a burden on the state as compared to the individual, Hopkins and Laurie are forced to admit that ‘social care is closely allied to health care, both in its substance and in the public’s perception’,³⁴¹ and that ‘the division between them’ is fuzzy’.³⁴² It is also significant that the ECtHR itself referred to Elaine McDonald’s predicament as involving a ‘measure reducing the level of her healthcare’,³⁴³ notwithstanding the fact that it falls within social care as a matter of domestic law.

³³⁷ Commission on the Future of Health and Social Care in England, *The Social Care and Health Systems of Nine Countries* (King’s Fund 2014) 11.

³³⁸ (1979-80) 2 EHRR 330 [63], but cf [50].

³³⁹ Herring, *Medical Law and Ethics* (n 20) 51.

³⁴⁰ King’s Fund (n 204) 3.

³⁴¹ Hopkins and Laurie (n 4) 113.

³⁴² *ibid* 114.

³⁴³ (2015) 60 EHRR 1 [47].

The extent of the apparent discrimination between users of the two types of service is arguably increased by the uncertain boundary between them, although given the deference shown under the ECHR in this area a substantive claim under Article 14 to this effect is unlikely to succeed. In *Nitecki v Poland*,³⁴⁴ the Court made an admissibility decision relating to Poland's refusal to fund the full cost (rather than the 70% that it did refund) of a life-saving drug. The applicant unsuccessfully claimed violations of Articles 2, 8 and 14. The Court emphasized that Article 14 prohibited only 'differences in treatment which have no objective or reasonable justification', and found 'such justification to exist in the...health care system which makes difficult choices as to the extent of public subsidy to ensure a fair distribution of scarce financial resources'.³⁴⁵

The ultimate insult could be not only that the situation in *McDonald* could still happen under the Care Act *and* that it would apparently be perfectly compatible with the ECHR, but also that a care recipient in Ms McDonald's situation could still be lawfully liable to make a financial contribution towards care that does not fully meet her needs. It does not appear that Ms McDonald herself was expected to contribute anything towards her care, and admittedly a care recipient wealthy enough to be charged even under the new means-tested threshold (if implemented) seems likely to choose to pay for care that meets her needs adequately. A person who is subjected to a negative resource allocation decision by an LA (such as those considered in Section 2) and does not have the means to pay for more suitable care is obviously more seriously prejudiced than someone who is merely caught by the charging regime, and Herring rightly recognizes the stronger claim of 'those seeking to protect...social care services for the poorest'.³⁴⁶ Matters will become particularly problematic, moreover, if LA resources are more stretched a result of people reaching the cap such

³⁴⁴ App no 65653/01 (ECtHR, 21 March 2002) (Admissibility Decision).

³⁴⁵ *ibid* [3]. Cf, eg, *Kjartan Ásmundsson v Iceland* (2005) 41 EHRR 42.

³⁴⁶ Herring (n 7) 146.

that LAs struggle more to meet the needs of those who literally cannot afford to pay for their care, although only a minority are likely reach the cap and the emphasis is on ensuring that ‘everyone will benefit from knowing that they will be covered’.³⁴⁷ It is still significant that extra care paid for by a wealthier person would not contribute to progress towards the cap if the needs were not considered eligible or an LA would have spent less in meeting eligible needs. The fact remains that the new system could fail fully to meet the needs of a social care recipient in a manner consistent with her dignity and charge her for the privilege of enduring that failure. Unless Baroness Hale’s approach is somehow resurrected, taken seriously and applied to Article 8, the ECHR can do little to help.

4. Conclusions

Amongst its analysis of the detail of the new social care legislation, and the regulations and guidance required to implement it, this article raises difficult questions about the proper role of a doctrinal legal scholar in evaluating law that is so inherently bound up with politics, social policy and public expenditure, notwithstanding the fact that social care raises important issues for those concerned with black-letter property law. The article has attempted to evaluate the Care Act against the benchmark of the ECHR. That evaluation has demonstrated the limitations of such an approach in the context of the most influential human rights treaty within English Law. The reality is that the old system was systemically consistent with the ECHR (even if there could be breaches in individual cases) as regards its protection of both the right to respect for private life and that to peaceful enjoyment of possessions, particularly given the deferential approach of the ECtHR on matters such as health and social care. The new system heralded by the Care Act will make compatibility more likely if fully implemented, but viewed from a human rights perspective its

³⁴⁷ Hopkins and Laurie (n 4) 131.

impact appears limited in some respects even though it has *formally* extended the human rights protection offered to social care recipients in others. The combined effect of LA discretion, underinvestment and the imposition of asset-based welfare caused by the continuing liability to pay for social care (and not health care, for example) using one's own property still supports the claim that the normative rights and the inherent dignity of some individuals are prejudiced by the system, although the decline in home ownership may ultimately reduce the scope for the Act to interfere with property rights for generations to come.³⁴⁸

³⁴⁸ *ibid* 125.