The Health Foundation's response to the Health and Social Care Select Committee inquiry on *social care: funding and workforce*

June 2020

About the Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

Acknowledgement

We are grateful to academic researchers at the Personal Social Services Research Unit (PSSRU) for contributing a summary of recent evidence on workforce recruitment and retention issues, which informed this submission. More information about the unit's research on recruitment and retention in the social care workforce, which is funded by the Health Foundation, can be found here.

Summary of key points

- The adult social care system in England needs fixing and has done for decades. Increasing numbers of people are unable to access social care, there are systemic and significant workforce issues and many care providers are at risk of collapse.
- The COVID-19 pandemic has revealed and exacerbated many of the long-standing problems facing the adult social care sector. The full effects of the pandemic are uncertain and will unfold over many months. What is certain, however, is that without funding and more fundamental reform, people and their families – as well as staff – will continue to suffer unnecessarily.
- Policies to improve and reform adult social care will not be successful unless they understand and address the needs of younger adults, who must not be forgotten in the policy debate about social care.

- Taking into account an ageing population, spending per person on adult social care services has fallen by around 12% in real terms between 2010/11 and 2018/19. Overall spending is increasingly reliant on transfers from the NHS.[1]
- The numbers receiving care have reduced and self-reported disability in the younger adult population (aged 18 to 64) has increased.[2]
- Based on our assessment of the evidence,[3] the five priorities for government should be:
    - stabilising and sustaining the current system
    - improving access to care
    - providing social protection against care costs
    - using the capped cost model as a flexible approach to reform
    - exploring a range of options for raising revenue.
- The Health Foundation have calculated a range of estimates for the adult social care funding gap, depending on the scale of the government's ambition for making improvements in the sector. Compared to current government funding plans for local authorities, we estimate that between £2.1bn and £12.2bn of additional funding may be needed annually in 2023/24. This is before accounting for the impact of COVID-19 on local authority incomes and the demand for state funded adult social care.[4]
- Delivering funding at the lower end of this range would just meet projected growth in demand from an ageing population; the higher end would allow access to care to be expanded and enable pay for front-line workers to be improved. This higher level of funding would provide improved access to services, supporting older people and the most vulnerable younger adults. It would also alleviate pressure on the NHS.
- There is a range of evidence available on the impact of social care on the NHS, including studies that have found:
    - Around 30% of bed days for people delayed in hospital over the last year were attributable to the patient having no social care arrangements in place, for example, due to patients awaiting care packages.[5]
    - There is a positive relationship between high social care spending and reduced hospital use and vice-versa.[6]
    - Emergency admissions are particularly high in residential homes compared with nursing homes, many of which are avoidable.[7]

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[1] https://www.health.org.uk/publications/long-reads/health-and-social-care-funding
[2] https://www.kingsfund.org.uk/publications/social-care-360
[3] Health Foundation (2019) *What should be done to fix the crisis in social care? Five priorities for government:* https://www.health.org.uk/news-and-comment/blogs/what-should-be-done-to-fix-the-crisis-in-social-cwre
[4] All estimates expressed in 2020/21 prices, see Appendix and https://www.health.org.uk/news-and-comment/charts-and-infographics/social-care-funding-gap
[5]See NHS England "Delayed Transfers of Care Time Series", Delays by responsible organization. Jan 2019 to Jan 2020 https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2019-20/
[6] See for example Institute for Fiscal Studies (2018) https://www.ifs.org.uk/uploads/publications/wps/WP201815.pdf and Spiers et al. (2018) https://eprint.ncl.ac.uk/file_store/production/250485/54D5774B-5EF5-4122-B9B6-6544E3D46C8A.pdf
[7] https://www.health.org.uk/publications/reports/emergency-admissions-to-hospital-from-care-homes

- While the relationship with the NHS is important and a well-functioning social care system is essential for a successful health service, looking at the issues facing social care through this narrow lens would be a mistake – ignoring the vital role that the social care system plays in people's lives in and of itself. It would also overlook the important interactions between social care and other vital public services, like housing, and the impact the lack of formal services have on unpaid carers' lives and ability to work.
- There are a wide range of challenges affecting the adult social care workforce. Around 1.5 million people work in the adult care sector. High staff turnover means approximately 440,000 leave their job each year (a third leaving the sector); there are almost 120,000 vacant posts, at 8% a much higher rate than other parts of the economy; a quarter of staff are employed on zero hours contracts; and more and more staff are being paid at or close to the National Living Wage, potentially contributing to increasing vacancy rates.[8]
- Close to 140,000 additional full-time equivalent social care staff[9] and an estimated 70,000 additional care home places[10] are needed over the next 5 years. To reverse these trends and meet these challenges, low pay and zero hours contracts need to be addressed, additional funding provided and system reform put in place alongside a national strategy for the workforce.
- The government's post-Brexit migration policy looks set to make addressing these challenges even harder. Skills for Care data suggest that 17% of social care staff in England are from other EU or non-EU countries and this rises as high as 40% in London. A sector specific immigration route should be introduced for the adult social care workforce.

1. What impact is the current social care funding situation having on the NHS and on people who need social care?

- Taking into account an ageing population, spending per person on adult social care services has fallen by around 12% in real terms between 2010/11 and 2018/19. Overall spending levels are becoming increasingly reliant on transfers from the NHS and have not kept up with demand.[11]
- Funding and reform are urgently needed to improve the quality of services, achieve the 2014 Care Act vision of putting individual wellbeing at the centre of services, and have a positive impact on the NHS. Steps must be taken to ensure the sector is properly resourced so that it can meet the rising tide of unmet need.

[8] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/State-of-Report-2019.pdf
[9] https://www.ifs.org.uk/uploads/publications/comms/R143.pdf
[10] Kingston et al. (2017) 'Is late-life dependency increasing or not?' A comparison of the Cognitive Function and Ageing Studies (CFAS), The Lancet (10103), P1676-1684, OCTOBER https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31575-1/fulltext
[11] https://www.health.org.uk/publications/long-reads/health-and-social-care-funding

- Reductions in funding mean the number of older people receiving publicly funded care fell by 400,000 between 2009/10 and 2015/16. Many more go without the care they need. Around one in 10 people aged 65 face future lifetime care costs of over £100,000.[12]
- Self-reported disability among the younger adult population (aged 18 to 64), who make up around a third of care users and over half of local authority spending on social care, has also increased. As outlined in our recent report, the proportion of younger adults reporting a disability increased from 14% in 2007/08 to 18% in 2017/18. When combined with population growth, the absolute number of younger adults with a disability rose by 35%.[13] Too many are likely to be missing out on the kind of support they require.

Impact on the NHS

- The role of adult social care in how well the NHS works is well recognised at a national policy level. The NHS Long Term Plan in England was developed on the basis that 'both the wellbeing of older people and the pressures on the NHS are linked to how well social care is working. When agreeing the NHS' funding settlement the government therefore committed to ensure that adult social care funding is such that it does not impose any additional pressure on the NHS over the coming five years.'[14]
- There is a range of evidence about the impact of funding and availability of adult social care services on the NHS. The quality of the evidence is variable, however, and the volume of evidence is relatively low. The following is a summary of some key findings from recent publications:
    - The Health Foundation has analysed linked health and social care data and summarised evidence from four evaluations of care home interventions designed to improve health. The research found that emergency admissions are particularly high in residential homes compared with nursing homes. Around two in five of these may be avoidable: they were for conditions that are potentially manageable, treatable or preventable outside of a hospital setting, or that could have been caused by poor care or neglect.[15]
    - The Institute for Fiscal Studies has examined the relationship between A&E attendances and reductions in social care spending. They found that reductions in social care spending on people aged 65 and above have led to increased use of A&E services, both in terms of the average number of visits per resident and the number of unique patients visiting A&E each year. On average there was a 25% increase in attendances per resident. The financial impact of these additional A&E utilisation was modest; £3 increases for every £100 of social care spending reductions were found.[16]

[12] https://www.health.org.uk/news-and-comment/blogs/what-should-be-done-to-fix-the-crisis-in-social-care
[13] https://www.health.org.uk/sites/default/files/upload/publications/2020/Social%20care%20for%20adults%20aged%2018-64_Analysis.pdf
[14] Paragraph 1.57 NHS Long Term Plan https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/
[15] https://www.health.org.uk/publications/reports/emergency-admissions-to-hospital-from-care-homes
[16] Institute for Fiscal Studies (2018) https://www.ifs.org.uk/uploads/publications/wps/WP201815.pdf

- Two recent systematic reviews considered the availability and use of adult social care services and use of hospital services.[17] They conclude that the volume and quality of evidence available is relatively low and more robust evidence is needed to be confident of the scale of the relationships. Key findings include: residents of care homes with onsite nursing had fewer than expected admissions to hospital compared to those without nursing, higher social care expenditure, and greater availability of nursing and residential care were associated with fewer hospital readmissions, fewer delayed discharges, reduced length of stay and expenditure on secondary health care services. In this context, it is worth noting that Skills for Care has highlighted shortages and ongoing recruitment problems in nursing roles in both health and social care.[18] Little evidence is available on the influence of home-based social care and no data was found on the relationship with primary care use.
- NHS England data on delayed transfers of care shows that around 30% of bed days for people whose discharge from hospital was delayed over the last year were attributable to the patient having no social care arrangements in place, for example due to patients awaiting care packages.[19]

The challenge in identifying systematic relationships at a national level is most likely due to the variation in the way that services are organised locally, the complex relationships between the NHS and social care, and variation in the characteristics of local populations. Crucially, however, the case for adult social care should not just be looked at narrowly in terms of avoiding adverse impact on the NHS. While the relationship with the NHS is vital, this approach overlooks many important aspects of adult social care services to people and society. These include the impacts on quality of life and health outcomes for people receiving services, access to education and employment opportunities for people with learning disabilities, the support provided to people providing unpaid care so they can work, and the interaction with other vital public services such as housing and employment support.

2. What level of funding is required in each of the next 5 years to address this?

- Additional funding is vital to improve access to services, supporting older people and the most vulnerable younger adults. As outlined above, these services have seen substantial reductions in funding over the last decade, while demand has been growing.
- The Health Foundation have calculated a range of estimates for the adult social care funding gap, depending on the scale of government's ambition for making improvements in

[17] Spiers et al (2019) https://onlinelibrary.wiley.com/doi/pdf/10.1111/hsc.12798 and Spiers et al (2018) https://eprint.ncl.ac.uk/file_store/production/250485/54D5774B-5EF5-4122-B9B6-6544E3D46C8A.pdf
[18] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/State-of-Report-2019.pdf
[19] See NHS England 'Delayed Transfers of Care Time Series', Delays by responsible organisation. Jan 2019 to Jan 2020 https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2019-20/

the sector. We estimate that between £2.1bn and £12.2bn additional funding may be needed annually in 2023/24. This is before accounting for the impact of COVID-19 on local authority incomes and the demand for state funded adult social care.[20] More detail on the basis of these estimates can be found in the Appendix.

- Our estimates of the funding gap are based on a comparison of projected funding for adult social care services under current government plans and the additional funding needed to address fundamental challenges facing the adult social care sector. We also make assumptions the local authorities will continue to protect adult social care services in the face of pressures on other services they provide. The amount required to plug this funding gap varies depending on the level of ambition for improving services. Additional funding at the lower end of the range would just meet the projected growth in demand from an ageing population – it would not provide funding to address unmet need, improve pay, terms and conditions for the workforce or addresses provider sustainability. The higher end of the range would allow access to be expanded and enable pay increases for front line workers.
- We have modelled four scenarios for addressing the funding gap:
    - **Meet future demand –** this is the base option where additional funding provided keeps up with underlying demand from an ageing population – we estimate this gap is approximately £2.1bn.
    - **Increase pay –** this means keeping up with future demand and providing addition funding to increase the pay of the adult social care workforce. This should help address the vacancy rate which has risen from around 5.5% to 7.8% over the last 6 years, equivalent to 122,000 vacant posts at any one time[21] – we estimate this gap is approximately £3.9bn.
    - **Recover peak spending levels –** this means returning spending to the peak levels seen in 2010/11 – we estimate this gap is approximately £10bn.
    - **Recover peak spending levels and increase pay –** in addition to returning to peak levels of spending, providing additional funding to increase pay – we estimate this gap is approximately £12.2bn.
- In the sections below we present estimated costs of implementing more fundamental reforms. These cannot just be added to the size of the funding gap presented above. These policies would interact and costs would be higher. For example, if you increased pay and access in the sector at the same time as putting in place a cap on the amount people have to pay for adult social care, the combined costs of all three policies would be higher than each one individually.
- Going beyond meeting demand will help to address the issue of underpayment of care home and home care providers. For care homes, the Competition and Markets Authority

[20] All estimates expressed in 2020/21 prices, see https://www.health.org.uk/news-and-comment/charts-and-infographics/social-care-funding-gap

[21] https://www.health.org.uk/news-and-comment/charts-and-infographics/going-into-covid-19-the-health-and-social-care-workforce-faced-concerning-shortages

(CMA) estimated this is between £0.9bn and £1.1bn per annum.[22] For home care, the UK Home Care Association (UKHCA) estimate that the government would need to pay an extra £1.5bn per year to enable state-funded home care to be paid at their recommended minimum hourly price of £20.69 (as opposed to the median rate being paid by councils, i.e. £16.96).[23]

- In assessing our recommendations on the funding required for social care, it should be noted that the impact of the COVID-19 pandemic on the demand and availability of social care services is highly uncertain and not yet fully clear. Its effects are therefore not yet accounted for in our funding estimates. However, there are four main potential effects that should be considered when assessing the likely impact of COVID-19 on social care services:
    - the uncertain impact on demand for services as a result of death and disability
    - the impact on numbers of people eligible for state support as asset values will be affected by the length and depth of any future recession
    - the adequacy of short-term funding for providers and local authorities to deal with the pandemic
    - the medium-term impact that a recession would have on local authority budgets – for example through reduced incomes from business rates or parking charges.[24]

3. What is the extent of current workforce shortages in social care, how will they change over the next 5 years, and how do they need to be addressed?

The outlook for staff shortages within the social care system is concerning and there are a wide range of challenges facing the sector.

- As outlined in our briefing on the *Health and social care workforce: Priorities for the next government*, published in November 2019, workforce shortages stand at around 122,000, with 1,100 people estimated to leave their job every day – an annual leaver rate of almost a third. Around 1.5 million people in total work in the adult care sector.
- Social care workers are all too often at the sharp end of poor employment. A quarter of staff are employed on zero hours contracts and this rises to 40% in the domiciliary care workforce. Low pay is also an issue, with more and more staff being paid at or close to the National Living Wage, potentially contributing to increasing vacancy rates.[25] These issues have been recognised by the Low Pay Commission, which has highlighted non-

[22] These estimates are in 2017 prices taken directly from the Care Homes Market Study – Competition and Markets Authority (CMA) – Full Report – Paragraph 44 https://www.gov.uk/cma-cases/care-homes-market-study
[23] UKHCA - Homecare in the time of coronavirus
UKHCA - estimate of minimum home care hourly rate for 2020/21
[24] https://www.health.org.uk/news-and-comment/charts-and-infographics/social-care-funding-gap
[25] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/State-of-Report-2019.pdf

compliance with national living wage requirements as a risk in the sector,[26] and by the National Audit Office (NAO) in its report on the adult social care workforce in England published in 2018. The NAO report highlights that many providers and commissioners of care report that low pay for care workers contributes to high vacancy rates. They found a particular challenge with recruiting registered managers.[27]

- Staff costs are estimated to account for over half of total costs in residential and nursing homes and homecare businesses. Skills for Care's annual report[28] shows that workforce shortages are just one of the challenges facing the sector:
  - Staff turnover is rising and amounted to 30.8% for directly employed staff in 2018/19[29], meaning around 440,000 people change job each year. One third of these people leave the sector
  - An average of 4.8 days are lost to sickness absence, almost 7 million days per year
  - Social worker pay has fallen in real terms between 2012/13 and 2018/19
- The Care Quality Commission (CQC) have highlighted the negative impact of workforce shortages and turnover on quality of care, and how higher quality care tends to be provided when the workforce functions in a coordinated way across the health and social care system.[30]
- The long-term impact of COVID-19 on recruitment and retention in the adult social care workforce is unclear. In the short-term, the social care workforce has been disproportionately affected. The high proportion of people on zero hours contracts means that incomes are precarious as a result of the need to self-isolate due to COVID-19 and may dissuade people from self-isolating, which is vital to controlling the spread of COVID-19.
- As illustrated by Office for National Statistics (ONS) data and by Public Health England's recent review of disparities in the risk and outcomes of COVID-19, death rates from COVID-19 are significantly higher among the social care workforce, including when all cause deaths are examined. There have been well documented challenges with provision of Personal Protective Equipment (PPE) in the sector. The Health Foundation has commissioned surveys from Kent University to collect evidence on the impacts, with initial data available in the next couple of months.

How will workforce shortages change over the next 5 years?

[26] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/645462/Non-compliance_and_enforcement_with_the_National_Minimum_Wage.pdf
[27] https://www.nao.org.uk/wp-content/uploads/2018/02/The-adult-social-care-workforce-in- .pdf
[28] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/State-of-Report-2019.pdf
[29] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/State-of-Report-2019.pdf
[30] https://www.cqc.org.uk/sites/default/files/20180702_beyond_barriers.pdf

- The number of people aged 65+ and 85+ are projected to rise over the next 5 years and estimates of the social care funding gap presented above are partly based on this rising demand. Higher demand generally means more staff are needed to provide care. In our *Securing the Future* report produced alongside the Institute for Fiscal Studies, we estimated that around 140,000 extra full-time equivalent staff would be needed across the sector by 2023/24[31].
- Kingston et al. (2017) estimate that approximately 70,000 additional care home places will be needed by 2025.[32] Nuffield Trust estimate that between 50,000 and 90,000 home care workers are needed now to provide basic additional care to older people with high needs.[33]
- Around 17% of employees are from EU or non-EU countries and this rises as high as 40% in London. Under the government's immigration bill very few roles are likely to qualify and no specific route for social care workers is provided (for instance, in 2018/19, even the average senior care worker in England earned significantly less than the proposed £25,600 minimum salary threshold).
- Analysis from an ongoing ESRC funded study[34] suggests that while the overall share of migrant workers in social care jobs has been relatively stable since 2010, its composition has changed. The share of EU nationals has increased while that of non-EU nationals decreased. Combined with high turnover rates this highlights that, at least in the short to medium term, a certain level of migration is needed to maintain an adequate supply of workers in social care workforce. This is particularly the case in certain regions (primarily London, the South East, the South West and the East). Regional variations in turnover and vacancy rates are highly relevant in coordinating health and social care workforce strategies, as a higher share of social care leavers move to the NHS in London relative to other regions.
- Further, evidence from an expert panel survey[35] indicates that a sudden and significant decline in EU work driven migration is likely to widen the gap in the sector between workforce supply and demand in the current context of high vacancy and turnover levels, and have potentially serious consequences for the availability and quality of care. This is a particular concern given that only half of the direct care staff in England have formal qualifications, and the number of people taking up social care apprenticeships having declined by 58% in 2017/18 relative to 2016/17.

Proposals for how these workforce problems should be addressed

[31] https://www.ifs.org.uk/uploads/publications/comms/R143.pdf
[32] Kingston et al. (2017) "Is late-life dependency increasing or not? A comparison of the Cognitive Function and Ageing Studies (CFAS), The Lancet (10103), P1676-1684, OCTOBER https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31575-1/fulltext
[33] Nuffield Trust (2019) https://www.nuffieldtrust.org.uk/research/social-care-the-action-we-need
[34] http://circle.group.shef.ac.uk/portfolio/migrant-care-workers-in-the-uk/
[35] https://www.pssru.ac.uk/project-pages/sustainable-care/

- **A national strategy for the adult social care workforce must be developed alongside the NHS People Plan**:
  - A comprehensive workforce plan must be developed that covers social care as well as the NHS, as the two sectors are highly interlinked.
  - It is insufficient to rely on individual organisations to address the workforce problems in the sector. Co-ordinated action is needed from central government, recognising the interdependency between the health and social care workforce.
  - As a major employer, typically providing better pay, terms and conditions, and career progression than social care can afford, the NHS has a significant impact on the social care workforce.
  - Measures implemented to support the longer-term mental health and wellbeing of staff in NHS also need to apply to social care, even though they are not public sector employees.

- **More must be done to support better pay in the social care sector** – for instance by matching pay increases in the NHS:
  - To strengthen staff bargaining power, the government could establish a sectoral wage board to police wage setting and minimum standard enforcement and to promote increased investment in staff training.
  - A national pay scale for social care should be implemented as exists for the NHS, as there is currently no equivalent to a national pay scale for social care (similar to Agenda for Change in the NHS). Under the current system it is left to individual local authorities to develop initiatives to incentivise higher pay (e.g. through contracting) or for individual care providers to pay higher rates.

- Ongoing (unpublished) longer-term Kent University research on recruitment and retention in social care, funded by the Health Foundation[36], has also provided the following insights about the challenges and possible solutions for addressing workforce shortages in social care:
  - Analysis of Skills for Care's Adult Social Care Workforce Data Set (ASC-WDS) suggests that staff retention is positively linked to age, tenure and pay and negatively linked to employment on casual (i.e. zero-hours) contracts. The positive relationship between pay and retention may have important implications for the funding of social care services.
  - Retention policies may need to target younger employees and their needs in particular. The share of care workers on zero-hour contracts is particularly high for domiciliary care providers. Supporting care providers to increase employment with guaranteed hours is likely to improve staff retention rates.

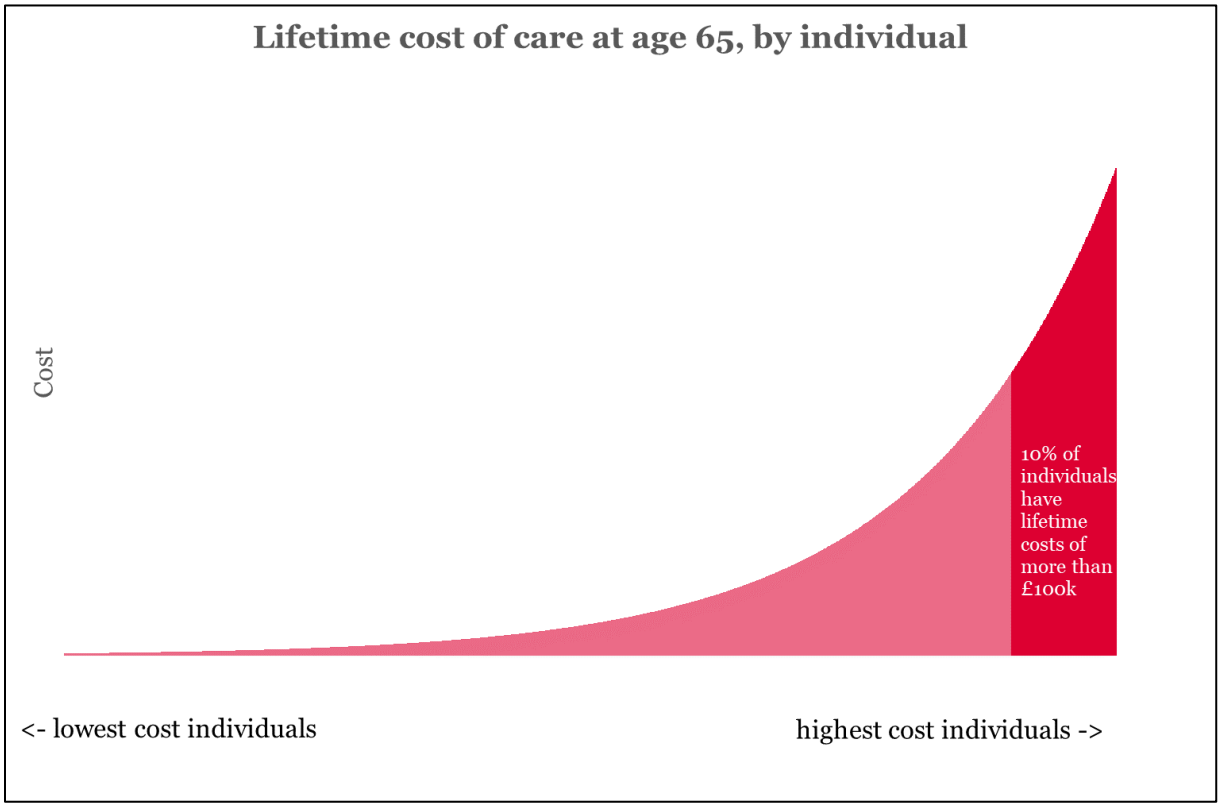
[36] https://www.pssru.ac.uk/resscw/frontpage/ – these findings are based on unpublished research from this project.

- In addition, given the significant proportion of social care employees who are from EU or non-EU countries, the government's migration policy looks set to make addressing the workforce challenges that are facing the sector even harder and needs to be re-considered. As outlined above, under the proposed system very few roles are likely to qualify based on salary and no specific route for social care workers is provided.

4. What further reforms are needed to the social care funding system in the long term?

The reforms outlined above are critical. But they do not address one of the key shortcomings of the system, which arises from how social care is currently paid for.

- The **current means-tested system** leaves people facing great uncertainty about the future costs they may incur – and is widely seen as unfair as those with the greatest care needs pay the most. This is a longstanding issue, which governments have repeatedly promised and then failed to address. Until it is fixed, the social care system will never be properly integrated with the NHS, or seen as a system of which we can be proud.
- Unlike in the NHS, whether you receive help from the state depends not just on your level of need but also on your wealth. Only those with the highest need and lowest means receive support. If you need care and have assets worth more than £23,250, you will have to pay for it, and this includes the value of your house if you're going into a care home.
- While some older people will live the rest of their lives without needing social care, a significant minority – those with intense care needs extending over many years – may face hundreds of thousands of pounds in costs. It's this issue that means that some people are forced to sell their homes to pay for care. This is shown in the chart below.



Fixing the issues with the current system requires some form of insurance against care costs. As the private sector does not and cannot offer this, the government must play a fundamental role in providing people with protection against social care costs, pooling risks across the population in a way the current system does not. But it leaves choices for policymakers about the kind of protection offered.

As we set out in our long read published in August 2019, *What should be done to fix the crisis in social care? Five priorities for government*, there are a number of different approaches that could be taken:

Making social care free and universal, in the same way as the NHS

- The most comprehensive, and expensive, policy option – with a cost of between £6bn and £11bn per year – would be to **make social care free**, in effect making it like the NHS. The range is large because the costs depend on a number of policy choices.
- The first is the ceiling on how much the state is prepared to pay for care. Local authorities typically pay upwards of £600 a week for a residential care place, but self funders pay around 40% more for the same place. If the state were to pay beyond the local authority rate, this would increase costs.
- The second is what contribution the state expects the individual to make to the costs of residential care. An individual living in their own home would pay general living costs

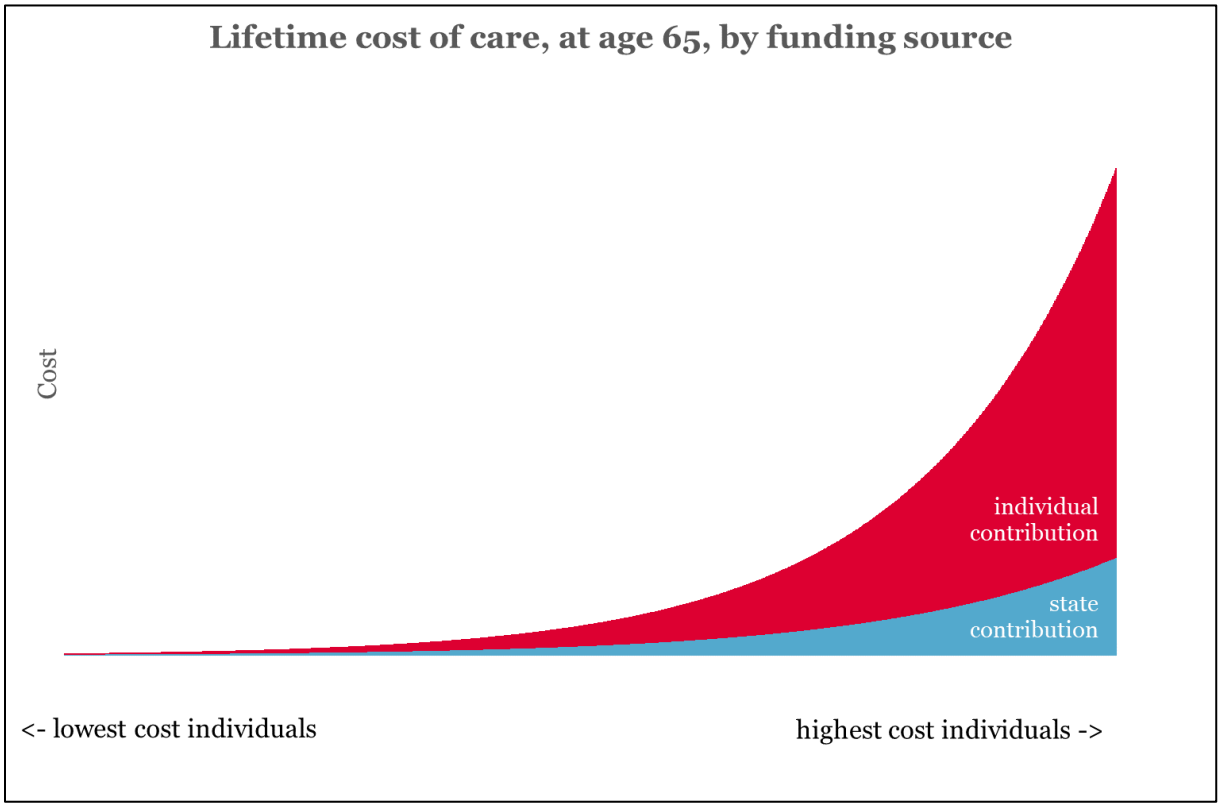
(e.g. accommodation and food); the cost to the state would depend on what contribution the state requires an individual to make towards these (e.g. £150 or £250 a week)

- The third is the level of need at which an individual becomes eligible for state funded care. Local authorities set eligibility thresholds which would currently exclude some of those paying privately for their care. If eligibility were to be widened to include these this would increase costs. Our lower estimate involves applying average state spending to those currently in the private system (so is therefore almost certainly an underestimate, given that self-funders pay higher rates to cross-subsidise low fees paid by local authorities).

- The upper estimate includes the gross costs of those currently in the private system. These figures are consistent with those from the NAO, which estimated in 2016-17 that privately bought care by self-funders without local authority involvement amounted to £10.9bn.
- This figure does not include the costs of meeting additional unmet need which may present as a result of the policy change which would push costs up. However, it also assumes that all private payers would have needs sufficient to qualify for state funded care, which may not be the case.

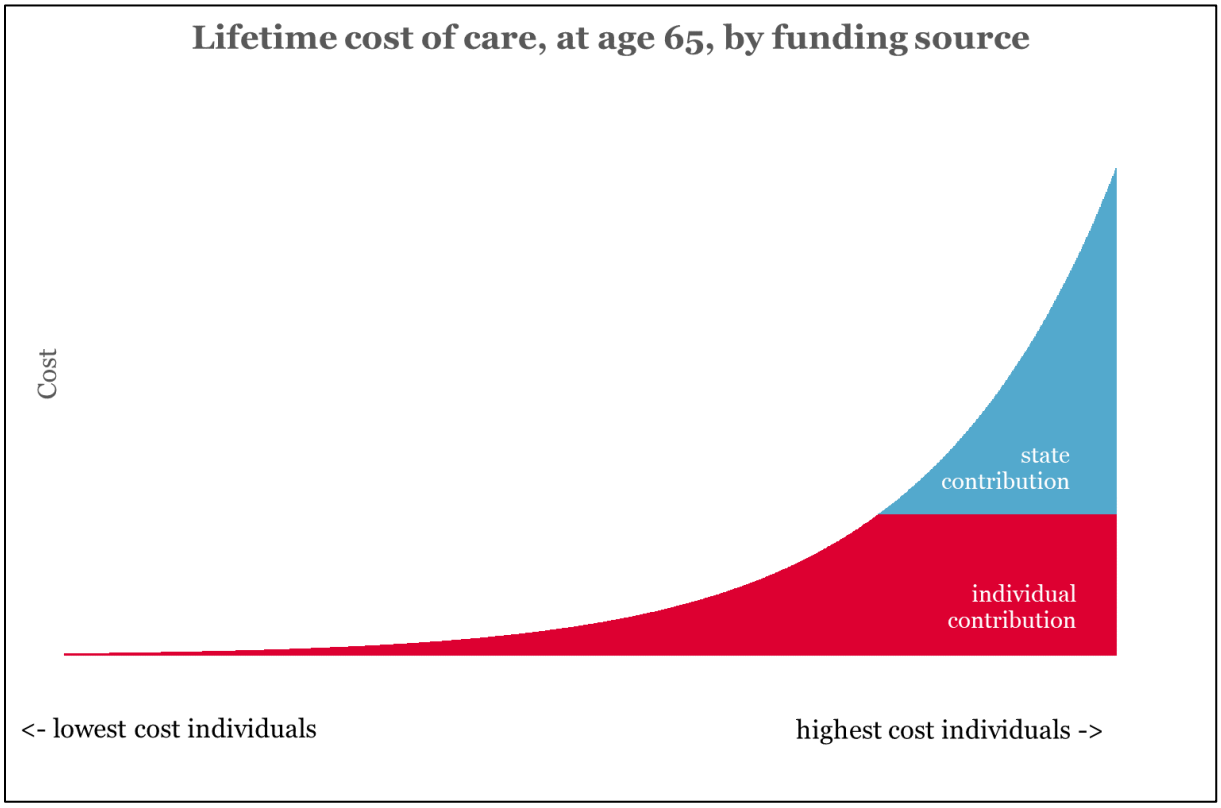
Free personal care: Providing basic protection for everyone

- Another approach would be for **the state to cover the costs of some services – for example, providing 'free personal care'** as in Scotland, which covers help with activities like washing and dressing.
- In Scotland the state contributes up to £180 a week to personal care costs for people living in care homes with a further payment of £81 to people who need nursing care. But individuals cover additional costs, including contributing towards living costs if they need residential care. Free personal care allowances in Scotland only meet around 25% of the weekly cost of a residential care home.
- Under this approach, the government is choosing to provide some level of social care support for all. For many, this would be an improvement on the current system. It would mean a more equal system for the care needs covered and clarity on the state's 'offer' to the population. But individuals with persistent and severe care needs – for example, a person with dementia, needing high intensity care for a decade – would still face high costs. And all individuals would still face uncertainty about what the future holds. This is shown pictorially below.
- Introducing a version of the Scottish system in England would cost around £5bn in 2023/24.



The capped cost model: Providing protection against catastrophic costs

- An alternative approach would be to target additional public spending on those who currently face the highest costs by **setting a cap on the amount they can expect to pay for care over their lifetime.** Once an individual's lifetime spend reaches the cap, their future care costs would be paid by the state. This approach is shown pictorially below.
- This is essentially the approach proposed by the Dilnot Commission in 2011 and it has the advantage of already being on the statute books as part of the 2014 Care Act, so could be easily activated by the government.



The table below sets out estimates of the costs for different levels of the cap. The lower the cap, the greater the protection to individuals but the greater the cost to government. A cap of £46,000, as recommended by Dilnot (in today's money), would mean that an older person entering a care home would pay for the first 2 years of their stay with the state paying after that. This would cost around £3.1bn in 2023/24.

Cap level	**Cost in 2023/24**
£0	£8.0bn
£25,000	£4.6bn
£46,000	£3.1bn
£78,000	£2.1bn

Note: These costs are based on calculations done using figures from the Dilnot Commission's report and assume increasing the upper capital threshold from £23,250 to £125,000 and that an individual in residential care would contribute up to £13,000 pa to their general living costs. They do not include extra costs needed to improve quality and access. It is assumed a cap is fully implemented now; in practice,

there would be a lag in implementation and costs would be low until significant numbers of people reach the cap.

A cap of zero is equivalent to providing free social care, but the cost depends on how much individuals in residential care are required to contribute to their living costs e.g. accommodation and food, and the maximum amount the state would pay towards care. If the system were more generous than the assumptions here, the cost of free social care would rise upwards from £8bn, towards a maximum of around £11bn.

Conclusion

The adult social care system in England needs fixing and has done for decades. Increasing numbers of people are unable to access social care and care providers are at risk of collapse. Yet successive governments continue to duck reform, and people and their families – as well as staff – continue to suffer unnecessarily.

These long-standing funding and workforce challenges facing the adult social care system are being compounded by the COVID-19 pandemic. Ongoing failure to reform the funding system will only prolong the uncertainty for older people and their families. Improved care for younger adults and their carers is also needed to support them to live independent lives. Combined with the knock-on impact on the NHS and other public services the case for additional funding and reform is compelling and urgent.

Appendix

Detailed explanation of cost estimates:

In 2018, 2019 and 2020 the Health Foundation carried out analysis of the challenges facing the social care sector, the funding needed to stabilise and improve access to the service and the cost of different policy options – for example, providing everyone with free personal care.

This tables below presents estimates and key assumptions from each analysis and explains why these have changed over time.

	Fork in the road May 2018	**What can be done to fix the crisis in social care?** Aug 2019	**General Election 2019** Nov 2019	**2020 update**
	• Gap in social care funding calculated up to **2020/21** Uses **2018/19 prices** and **2016/17 as a base year**.	• Gap in social care funding calculated up to **2023/24** Uses **2019/20 prices** and **2017/18 as a base year**.	• Gap in social care funding calculated up to **2023/24** Uses **2019/20 prices** and **2018/19 as a base year**.	• Gap in social care funding calculated up to **2023/24** Used **2020/21** prices and **2018/19 as a base year**.
Additional funding needed to:				
Meet future demand	• £1.5bn	• £2.7bn	• £2.4bn	• £2.1bn
Meet future demand and increase pay	• *Not in analysis*	• £4.4bn	• £4.1bn	• £3.9bn

Recover peak spending levels – return to 2009/10 spending (the highest total spending)	£8bn	*Not in analysis*	*Not in analysis*	*Not in analysis*
Recover peak spending levels – return to 2010/11 levels of spending				£10.0bn
Recover peak spending levels and increase pay	*Not in analysis*	£12.5bn	£12.2bn	£12.2bn
Bring in free personal care, along the lines of the Scottish model	£7bn	£5bn	£5bn	n/a
Bring in a cap on social care costs**	£5bn Based on a cap of £75k and increasing the	£2.1bn Based on a cap of £78k and an upper capital limit of £125k for	£2.1bn Based on a cap of £78k and an upper capital limit of £125k for	£2.1bn Based on a cap of £78k and an upper capital limit of £125k for

	lower capital limit to £100k. (this is the amount needed in 2020/21 and not directly comparable with the other columns, which are for 2023/24)	residential care only.	residential care only.	residential care only.
		£3.1bn Based on a cap of £46k and an upper capital limit of £100k for residential care only.	£3.1bn Based on a cap of £46k and an upper capital limit of £100k for residential care only.	£3.1bn Based on a cap of £46k and an upper capital limit of £100k for residential care only.
*Further analysis after the *Fork in the road* publication showed that 2010/11 represented the peak of social care spending per capita. This was then used in subsequent publications as the reference year for returning social care to previous levels of service.				

** The Dilnot Commission suggested a cap on social care costs of £35k in 2011. The government accepted a cap of £72k in 2016. The £46k and £78k caps are the 2020/21 equivalents of these.

Key assumptions:

Fork in the road

- Uses the Personal Social Services Research Unit's (PSSRU) projection of demand for adult social care[1]
- Our estimate of local authorities' core spending power assumes they continue to spend the same proportion of their total funding on social care
- Assumes councils raise maximum social care precept
- Free personal care costs based on the model of free personal care in Scotland

What can be done to fix the crisis in social care?

- Meeting future demand – equates to the funding required to match the PSSRU estimates of projected demand growth 2017/18
- Matching NHS pay increases – equates to the funding required for the adult social care sector to match for its staff the NHS long-term plan commitments to pay settlement
- Returning to 2010/11 levels of service and matching NHS pay – projects forward the level of demand from 2010/11 and includes the above pay increases

General Election 2019 update

This analysis uses similar assumptions to the August 2019 publication, except that:

- It also reflects the Spending Review 2019 which made policy announcements with implications for local authority budgets in 2020/21
- The base year was changed from 2017/18 to 2018/19 to reflect updated NHS Digital data published in October 2019 on local authority spending on social care

2020 update

This analysis used similar assumption to the General Election 2019 publication. In addition:

- It reflects the commitment to extend additional funding made available at Spending Review 2019 to the end of this parliament