



House of Commons

Health and Social Care and
Housing, Communities and
Local Government Committees

Long-term funding of adult social care

*First Joint Report of the Health and
Social Care and Housing, Communities
and Local Government Committees of
Session 2017–19*

*Ninth Report of the Health and Social
Care Committee*

*Seventh Report of the Housing,
Communities and Local Government
Committee*

*Report, together with formal minutes
relating to the report*

*Ordered by the House of Commons
to be printed 19 June 2018*

Health and Social Care Committee

The Health and Social Care Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and Social Care.

Current membership

[Dr Sarah Wollaston MP](#) (*Conservative, Totnes*) (Chair)

[Luciana Berger MP](#) (*Labour (Co-op), Liverpool, Wavertree*)

[Mr Ben Bradshaw MP](#) (*Labour, Exeter*)

[Dr Lisa Cameron MP](#) (*Scottish National Party, East Kilbride, Strathaven and Lesmahagow*)

[Rosie Cooper MP](#) (*Labour, West Lancashire*)

[Diana Johnson MP](#) (*Labour, Kingston upon Hull North*)

[Johnny Mercer MP](#) (*Conservative, Plymouth, Moor View*)

[Andrew Selous MP](#) (*Conservative, South West Bedfordshire*)

[Derek Thomas MP](#) (*Conservative, St Ives*)

[Martin Vickers MP](#) (*Conservative, Cleethorpes*)

[Dr Paul Williams MP](#) (*Labour, Stockton South*)

The following Members were members of the Committee during the session:

[Dr Caroline Johnson MP](#) (*Conservative, Sleaford and North Hykeham*)

[Maggie Throup MP](#) (*Conservative, Erewash*)

Housing, Communities and Local Government Committee

The Housing, Communities and Local Government Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Ministry of Housing, Communities and Local Government.

Current membership

[Mr Clive Betts MP](#) (*Labour, Sheffield South East*) (Chair)

[Mike Amesbury MP](#) (*Labour, Weaver Vale*)

[Bob Blackman MP](#) (*Conservative, Harrow East*)

[Helen Hayes MP](#) (*Labour, Dulwich and West Norwood*)

[Kevin Hollinrake MP](#) (*Conservative, Thirsk and Malton*)

[Andrew Lewer MP](#) (*Conservative, Northampton South*)

[Jo Platt MP](#) (*Labour (Co-op), Leigh*)

[Mr Mark Prisk MP](#) (*Conservative, Hertford and Stortford*)

[Mary Robinson MP](#) (*Conservative, Cheadle*)

[Liz Twist MP](#) (*Labour, Blaydon*)

[Matt Western MP](#) (*Labour, Warwick and Leamington*)

Powers

The Health and Social Care and the Housing, Communities and Local Government Committees are departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

Publication

Committees' reports are published on their websites at www.parliament.uk/hscocom and www.parliament.uk/hclg and in print by Order of the House.

Evidence relating to this report is published on the [inquiry publications page](#) of the Committees' websites.

Health and Social Care Committee

Committee staff

The current staff of the Committee are Huw Yardley (Clerk), Seth Roberts (Second Clerk), Laura Daniels (Senior Committee Specialist), Lewis Pickett (Committee Specialist), Dr Juliette Mullin (Clinical Fellow), Cecilia Santi O Desanti, (Senior Committee Assistant), Ed Hamill (Committee Assistant) and Alex Paterson (Media Officer).

Contacts

All correspondence should be addressed to the Clerk of the Health and Social Care Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is hscocom@parliament.uk.

Housing, Communities and Local Government Committee

Committee staff

The current staff of the Committee are Edward Beale (Clerk), Jenny Burch (Second Clerk), Tamsin Maddock (Senior Committee Specialist), Nick Taylor (Committee Specialist), Tony Catinella (Senior Committee Assistant), Eldon Gallagher (Committee Support Assistant), Gary Calder and Oliver Florence (Media Officers).

Contacts

All correspondence should be addressed to the Clerk of the Housing, Communities and Local Government Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 4972; the Committee's email address is hclgcom@parliament.uk.

Contents

Summary	3
Introduction	6
1 The state of social care	8
Funding pressures	8
Demand and cost pressures	8
Reductions in spending on publicly funded social care	9
Additional funding for social care, 2016–17 to 2019–20	9
The funding gap	10
The impact of the funding pressures	10
Unmet and under-met need	10
Increasing reliance on unpaid carers	11
The workforce	11
Quality	12
Care providers under pressure	12
A fragile care market	13
Conclusion	13
2 Principles for funding social care	16
Good quality care	17
Considering working age adults as well as older people	17
Ensuring fairness between the generations	18
Aspiring over time towards universal access to personal care free at the point of delivery	19
Risk pooling—protecting people from catastrophic costs, and protecting a greater portion of their savings and assets	19
‘Earmarked’ payments	20
3 Options for funding social care	21
How much funding is needed?	21
Meeting future demand	21
Funding good care	23
Reforms	25
Conclusion	36
Options for raising extra funding	37
Current funding arrangements	37
Future revenue-raising options	38

Funding social care in other countries—‘social insurance systems’	40
Conclusions and recommendations	43
4 Social care and its wider context—health, public health and housing	46
Interdependencies between health and social care	46
Delivery and integration at a local level	47
Social care, health and public health funding	49
Housing	50
5 Political and public consensus on social care	52
A cross-party approach: a parliamentary commission	52
Public engagement	55
Conclusions and recommendations	57
Annex: Note of visit to New Deanery Care Home, Braintree	64
Formal minutes	70
Witnesses	73
Published written evidence	74
List of Reports from the Committees during the current Parliament	79

Summary

The combination of rising demand and costs in the face of reductions in funding has placed the social care system under unsustainable strain. In its present state, the system is not fit to respond to current needs, let alone predicted future needs as a result of demographic trends. After successive attempts at reform the social care Green Paper must be the catalyst for achieving a fair, long-term and sustainable settlement. Failure to do so will undermine the effectiveness of the welcome recent announcement of an uplift in NHS England spending.

Spending on social care needs to rise to: meet the funding gap for the provision of social care by local authorities in 2020; provide the additional funding to meet future demand; meet the care needs of everyone, whether critical, substantial or moderate; and to improve the quality of care delivered, which includes ensuring the stability of the workforce and care providers.

Future spending on social care

The following principles should inform and direct the forthcoming discussions about how to reform social care and how to raise the additional funding needed:

- Providing high quality care
- Considering working age adults as well as older people
- Ensuring fairness on the ‘who and how’ we pay for social care, including between the generations
- Aspiring over time towards universal access to personal care free at the point of delivery
- Risk pooling—protecting people from catastrophic costs, and protecting a greater portion of their savings and assets
- ‘Earmarking’ of contributions to maintain public support

Costings of future provision of social care need to begin with a clear articulation of what good care looks like and costs for both older adults and working age adults— simply extending the current, inadequate provision of social care to more people is not a tenable long-term position.

We support the provision of social care free at the point of delivery as a long-term aspiration. **In principle, we believe that the personal care element of social care should be delivered free to everyone who has the need for it, but that accommodation costs should continue to be paid on a means-tested basis.** This should begin by extending free personal care to those deemed to have ‘critical’ needs. However, particularly for younger adults, it is essential that social care is viewed more holistically and funding for ‘preventative’ social care for adults with moderate social care needs is reinstated.

Raising additional funding

There is a clear need for increased funding for social care. Given the scale of the additional funding likely to be needed, a combination of different revenue-raising options will need to be employed, at both a local and a national level.

Local level

- There should be a **continuation for the foreseeable future of the existing local government revenue streams**. In 2020, these funding streams should be enhanced through 75% business rate retention used to fund social care rather than the replacement of grants the Government is proposing to introduce. In the medium term, there should be a **reform of the council tax valuations and bands** to bring them up-to-date. In the future, as other funding streams develop, the contribution from council tax and business rates to social care funding could reduce, allowing councils to better fund other important services.

National level:

- Local government funding will only ever be one part of the solution for social care, and it is clear that **extra revenue will also need to be raised nationally**. We heard strong support for the principle of earmarking contributions—it was felt that establishing a visible fund that is clearly, transparently and accountably linked to spending on social care is key to gaining public acceptance for this measure. We therefore recommend that **an additional earmarked contribution, described as a ‘Social Care Premium’, should be introduced**, to which employers would also contribute. This can either be as an addition to National Insurance, or through a separate mechanism similar to the German model.
- To ensure the accountability desired by the public, we believe that **the funding derived from the Social Care Premium should be placed in an appropriately named and dedicated fund. The fund should be regularly audited and required to publish its spending and accounts**. Following our principle of fairness between generations, we recommend that **those aged under 40 should be exempt from the Social Care Premium, and that it should also be paid by those over the age of 65**.
- Specific consideration should be given to setting a minimum earnings threshold for the Social Care Premium—to protect those on the lowest incomes—and to lifting the maximum threshold for such payments. Consideration should also be given to including unearned income, for example pensions and investments, in contribution calculations, as well as reforms to ensure that self-employed people pay equivalent contributions.
- There should also be consideration of the means for assessment of need and a mechanism for increasing the required premiums to meet changes in demand

over time. Wherever possible, these mechanisms should be independent statutory bodies to remove the short-term political cycles and decision-making from the process.

- As a further development, **the principle of having an earmarked fund that the public could see is for social care could be extended to funding of the NHS**, providing a consistency and coherence to the link between social care and the NHS, underpinned by closer working and integration at a local level. **In the long term, we believe there is a strong case for reimagining this as ‘National Health and Care Insurance’.**
- In order to remove the catastrophic cost of care for some people, and to spread the burden more fairly, we also recommend that **a specified additional amount of Inheritance Tax should be levied on all estates above a certain threshold and capped at a percentage of the total value.**

Health and social care integration

Health and social care are highly interdependent. While it will not of itself generate funding to address the social care shortfall, **further integration has the potential to improve outcomes and we recommend that local attempts to better integrate services continue apace.** There is a strong case for the local delivery of social care, which brings the important benefits of links with housing and other local services, as well as local accountability. Given the interdependencies between the provision of health care, social care, and also public health, we also recommend that in its discussions of future funding settlements the Government should consider all these in the round.

The mechanism for achieving consensus

There has been failure in the past to make progress on reform and a cross-party approach on reforming social care funding is now essential. The concept of a cross-party parliamentary commission currently has the support of more than 100 MPs from all English political parties. **As a proven mechanism for building and maintaining political consensus on difficult issues, and following other unsuccessful attempts at reform, we strongly recommend that a parliamentary commission offers the best way to make desperately needed progress on this issue** and that it should use the principles and proposals set out in this report as a basis for proceeding.

Introduction

1. For many people, help with personal care such as washing, dressing or eating is of crucial importance—because without it, they cannot live independent, dignified or safe lives. People of all ages, with a wide variety of needs, may depend on social care such as this.¹ Adult social care can range from weekly attendance at a day centre to a regular visit to help a person prepare and eat their meals to 24-hour care provided in a residential care home. The number of adults of working age who need social care is increasing as medical advances advance life expectancy, although healthy life expectancy lags behind.² The proportion of adults with care needs increases with age.³

2. However, social care and the mechanisms for funding it are not well understood.⁴ People are often surprised to learn that, in contrast with health services, social care is not free at the point of delivery—anybody with assets over £14,250 will have to make a contribution, and anybody with assets over £23,250 will have to fund it all themselves until their assets drop to that level.⁵ People are also often reluctant to think about the possibility that they or their family may need social care in the future, or how they might pay for it.⁶ It is estimated that 1 in 10 people may face ‘catastrophic’ care costs—of over £100,000—and it is not possible to purchase insurance to protect against this risk.

3. People with assets below the threshold may qualify for free social care. However, even for people below this threshold, not all social care needs are met. In 2014, 85% of older people lived in local authority areas where only ‘critical’ or ‘substantial’⁷ social care needs were funded, with funding not provided for those deemed to have moderate or low social care needs. The Care Act 2014 has now set a national eligibility threshold at a level where the person’s care and support needs have “a significant impact on their wellbeing”. This is broadly equivalent to the previous ‘substantial’ eligibility band.

4. The demand for social care will continue to increase as the population ages, and as an increasing number of younger people live longer with disabilities. Despite rising demand for social care, public spending on it has fallen in recent years. The number of people paying for their own social care (self-funders) without any assistance from public funding is increasing, and there is also a growing number of people who need care and are not getting it at all—people with unmet care needs. The way in which social care is currently funded also means that the cost burden falls very heavily on some individuals and their families, and not at all on others. There is also clear evidence that some diagnoses are more likely to result in higher needs and therefore disproportionate costs of social care—dementia, for example.

5. There is an urgent need to find sustainable funding for social care—both to increase the funding available for social care, and also to make the system fairer. Failure to do

1 Social care is also needed for some children, but is not the subject of this report.

2 Institute for Government, [Adult Social Care Performance Tracker](#), Autumn 2017

3 In the 65–69 age group, 8.2% of people are unable to conduct one or more activity of daily living (ADLs) without help; this rises to 17.6% of the 75–79 age group, and 44% of people aged 85 and over. [Source—PSSRU aggregate model]

4 The King’s Fund and the Health Foundation, [A fork in the Road - next steps for social care funding reform](#), (May 2018)

5 Ibid

6 [Q77](#)

7 These are formal categories of need. House of Commons Library Briefing, [Adult Social Care Funding \(England\)](#), (April 2018)

so will undermine the effectiveness of the welcome recent announcement of an uplift in NHS England spending. The Government is preparing a Green Paper on social care for older adults which is expected shortly⁸. A parallel process is running to address issues relating to social care for working age adults. Separating the issues in this way, and also failing to ensure a joined up or ‘whole systems’ approach to social care reform which takes into account its relationship with the NHS, public health and housing, risks a fragmented approach. Where appropriate, our recommendations consider social care’s wider relationship with other services.

6. Making decisions about the funding of social care is not easy, and numerous previous attempts at implementing reform have failed. Building a political consensus is much more likely to result in real progress, especially in a hung Parliament. We have therefore taken the unusual step in this report of addressing our recommendations to both sides of the political divide, asking that both the Government and the opposition front bench accept them.

7. An equally important step in reforming social care funding is that the public are made fully aware of the issues facing social care, and of the way in which it is currently funded. Decision making about a sustainable way of funding social care should involve the public as well as those who are currently in need of help with social care. Given the importance of public engagement in decision making about this issue, we decided to directly involve members of the wider public—including those who currently use social care—in our inquiry, through a Citizens’ Assembly.

8. A Citizens’ Assembly is a deliberative event, where members of the public from across a range of ages and backgrounds from across the country learn about and consider a subject before reaching agreed conclusions. We are extremely grateful to all those who gave up their time to participate in the Citizens’ Assembly. Its findings are reflected throughout this report.⁹

9. We also visited Sonnet Care Homes in Braintree in Essex to speak directly to people who use social care and their families, as well as people working in the care sector. The visit provided very useful insights and we are indebted to the staff and residents and families from both care homes for the welcome they extended to us, and for the frankness with which they spoke about their experiences.

10. We received written submissions from a wide range of organisations and are grateful to all those who engaged with our short inquiry in this way. We are particularly grateful to all the individuals who wrote to us sharing their experiences of using social care, and their views on future funding. These responses have been analysed thematically for us by the Parliamentary Office of Science and Technology.¹⁰

11. This report begins by setting out the current state of social care. We then present the six principles which we recommend should underpin future decisions about funding social care, and follow this with our specific recommended options. Finally, we discuss the need to consider social care in its wider context, including health, public health and housing, and then we discuss the steps necessary to achieve political and public consensus in this difficult area.

8 Green Papers are consultation documents produced by the Government. The aim of this document is to allow people both inside and outside Parliament to give the department feedback on its policy or legislative proposals.

9 [Citizens’ Assembly Report](#)

10 Analysis of Individual Submissions to the Parliamentary Office of Science and Technology ([FSC0195](#))

1 The state of social care

12. The critical state of social care and the very serious consequences for people who receive care, their unpaid carers and their families, as well as the NHS, is well-documented, not least by the Housing, Communities and Local Government (HCLG) Committee in its two reports of March 2017.¹¹ We begin, nevertheless, with a high-level description of the funding challenges facing the sector and their impact, as this provides essential context for the recommendations we make in this report and underlines the urgency of the need to act upon them.

Funding pressures

13. Our witnesses together represented all parts of the social care sector and included charities working on behalf of older people and younger adults, care providers, and local government, as well as academics and representatives of think tanks and the NHS. Their common assessment was that social care was under great strain due to rising demand for services at a time of increasing costs and reductions in social care budgets.¹² These factors are discussed in the following paragraphs.

Demand and cost pressures

14. Life expectancy is increasing, the population is ageing and adults with long-term health conditions and disabilities are living longer. While this is an extremely positive development which should be celebrated, it poses a significant challenge for the provision of social care. The National Audit Office (NAO) has estimated that, between 2010–11 and 2016–17, the number of people in need of care aged 65 and over increased by 14.3%.¹³ Furthermore, there are now 850,000 people with dementia in the UK,¹⁴ seven in ten of whom have a co-morbidity.¹⁵ And, between 2009–10 and 2013–14, the number of adults with learning disabilities rose by around 20%.¹⁶ John Jackson, Co-Lead of the Resources Policy Network at the Association of Directors of Adult Social Care (ADASS), estimated that demographic pressures were costing local authorities “about £400 million a year [...] It is £157 million for older people and £243 million for younger adults”.¹⁷ It is notable that over half of these additional cost pressures arise from care and support to meet the needs of working age adults.

15. Local authorities have also faced a range of other cost pressures, namely the National Living Wage (NLW), the Apprenticeship Levy and increased National Insurance contributions, as well as growth in the total population of 5% between 2010–11 to 2016–17.¹⁸ The NLW, which is being introduced incrementally between 2016 and 2020, has had the most significant impact on local authority social care budgets as care providers require

11 Housing Communities and Local Government (HCLG) Committee, [Adult social care: a pre-Budget report](#), Eighth Report of Session 2016–17 (March 2017); HCLG Committee, [Adult social care](#), Ninth Report of Session 2016–17, HC 1103 (March 2017)

12 [Q35](#)

13 National Audit Office, [Financial sustainability of local authorities 2018](#) (March 2018)

14 Alzheimer’s Society ([FSC0158](#))

15 [Q2](#)

16 Learning Disabilities Observatory, [People with Learning Disabilities in England 2015](#), Public Health England (2016)

17 [Q113](#)

18 National Audit Office, [Financial sustainability of local authorities 2018](#) (March 2018)

fee uplifts to cover their increased staffing costs. Although giving care workers a much-needed increase in pay, the introduction of the NLW has had a substantial impact on the care sector where wages are typically very low. The Association of Directors of Adult Social Care (ADASS) has calculated that, in 2018–19, the NLW and associated National Minimum Wage implementation will cost councils an additional £466 million.¹⁹

Reductions in spending on publicly funded social care

16. The rising demand and cost pressures described above have landed at a time of reducing spending on social care. Since 2010, local authorities have had to cope with a 49.1% real terms reduction in the core grant they receive from central government, which equates to a 28.6% real-terms reduction in their ‘spending power’ (government funding, council tax and retained business rates).²⁰ As the largest area of discretionary spend, comprising over a third (37.8%, £14.8 billion net)²¹ of their total spending in 2017–18, adult social care budgets have contributed to the savings local authorities have been required to make, with real terms expenditure on adult social care falling by -5.8% from £15.8 billion in 2010–11 to £14.9 billion in 2016–17.²²

17. Recently, reductions in spending on social care have slowed as a result of the Government’s decision to provide some additional short-term funding in the form of the adult social care support grant, the adult social care precept and the allocation of funding from the improved Better Care Fund.²³ In addition, local authorities have been protecting their social care budgets by spending less on other services, reducing their spending on social care by 3.3% in real terms compared to reductions in spending of 52.8%, 45.6% and 37.1% in real terms on planning and development, housing services, and highways and transport respectively.²⁴

Additional funding for social care, 2016–17 to 2019–20

18. As referred to above, in recognition of the funding pressures on adult social care, the Government has introduced a series of additional short-term funding measures, stated to amount to an additional £9.4 billion funding for adult social care between 2016–17 and 2019–20.²⁵ Although the additional resources have been welcomed, we heard that they were not sufficient to resolve the funding pressures facing social care. The Local Government Association (LGA) said that each of these funding mechanisms had “limitations” and did “not deal with all short-term pressures, let alone address the issue of longer term sustainability”, describing the Government’s response as “short term and incremental in nature”.²⁶ After considering the evidence it heard on the new funding mechanisms, the then Communities and Local Government Committee came to a similar conclusion in its pre-Budget report, highlighting, among other things, the lack of correlation between the amount raised by the precept²⁷ and local need for care and local variation in the amount it could raise.²⁸

19 Association of Directors of Adult Social Care, [Budget Survey 2018](#) (June 2018)

20 National Audit Office, [Financial sustainability of local authorities 2018](#) (March 2018)

21 Association of Directors of Adult Social Care, [Budget Survey 2018](#) (June 2018)

22 House of Commons Library Briefing, [Adult Social Care Funding \(England\)](#) (February 2017)

23 As announced in the 2017–18 Local Government Finance Settlement and in the Spring Budget 2017

24 National Audit Office, [Financial sustainability of local authorities 2018](#) (March 2018)

25 HC Deb 25 November 2015 [cc1363–1364](#)

26 The Local Government Association ([F5C0049](#))

27 The adult social care precept allowed councils to raise council tax by 2% and later 3% in 2017–18 and 2018–19.

28 HCLG Committee, [Adult social care: a pre-Budget report](#), Eighth Report of Session 2016–17 (March 2017)

The funding gap

19. Many organisations say that, even taking into account the additional funding, there is a ‘funding gap’ in adult social care resulting from an accumulation over the years of the demand, cost and funding pressures detailed above. We were presented with estimates of the funding gap: Simon Bottery, Senior Fellow in Social Care at The King’s Fund, said that his organisation, together with the Health Foundation and the Nuffield Trust, had estimated it at £2.5 billion by 2019–20,²⁹ while Sarah Pickup, Deputy Chief Executive of the LGA, said that her organisation had estimated a £2.2 billion gap by 2019–20, £1.3 billion of which was needed to stabilise the care provider market.³⁰ In addition, the Competition and Markets Authority (CMA) has estimated that the care home market across the UK (therefore excluding domiciliary care) is underfunded by around £0.9 to £1.1 billion a year.³¹ It is notable that analysis by the NAO of the estimates submitted to the HCLG Committee during its 2017 adult social care inquiry found that, accounting for differences in the bases of calculation, these three estimates were consistent.³² Both our witnesses emphasised that their organisation’s estimates were based on maintaining current levels of care.³³ Sarah Pickup explained that the LGA’s estimate “address[es] the very basic issues of demographic growth, inflation, the national living wage and the provider market stability—the basics of keeping the same care going” and did not include unmet need, investment in prevention and early intervention or the cost pressures arising from the ruling on sleep-ins, which we discuss in more detail in paragraph 27.³⁴

20. The recent additional funding commitments for adult social care, although welcome, are short-term, ad hoc and do not represent a sustainable solution for the long term. **Authoritative sources in the social care sector say that, despite the additional funding, there will be a funding gap of £2.2–£2.5 billion in 2019–20. Before further reform of the system can be contemplated, the funding gap must be closed. Upfront funding will also be needed for transformation issues. The issue of backdated pay for sleep-ins also presents an immediate risk to organisations’ financial stability and must be addressed urgently.**

The impact of the funding pressures

21. The funding pressures have had serious consequences for all parts of the social care system and particularly people who need care and support. These consequences are well-documented: Sir Andrew Dilnot, Chairman of the 2011 Commission on the Funding of Care and Support, told us that the system had been under great strain for many years and that it was consequently now at risk of “fairly significant disaster”.³⁵

Unmet and under-met need

22. As a result of funding pressures, local authorities are providing care and support to fewer people and concentrating it on those with the highest levels of need. Despite rising

29 [Q38](#)

30 [Q105](#)

31 [CMA \(FSC0172\)](#)

32 [Letter from National Audit Office to the Chair of the HCLG Committee regarding adult social care funding](#) (30 January 2018)

33 [Q39](#) [Simon Bottery], [Q106](#) [Sarah Pickup]

34 [Q106](#)

35 [Q55](#)

need for care, the number of people receiving publicly funded care fell by 400,000 between 2009–10 and 2016–17 and it is estimated that 1.2 million older people may now have unmet care needs.³⁶ People in receipt of care are finding that their needs are ‘under met’—Anna Bird, Executive Director of Policy and Research at Scope, told us that working age adults were seeing their care “restricted to the basics of personal care” rather than receiving care which promoted their independence and enabled them to live as full a life as possible.³⁷

Increasing reliance on unpaid carers

23. Rising levels of unmet and under-met need have led to unpaid carers stepping into the breach, and providing an estimated £132 billion worth of care each year.³⁸ Since 2001, the number of people providing 20–49 hours of care a week has increased by 43%.³⁹ It is not certain that the number of unpaid carers will keep pace with the need for support.⁴⁰ Dominic Carter, Senior Policy Manager at the Alzheimer’s Society, said that three in five unpaid carers had told his organisation that their health was failing as a result of their care-giving.⁴¹ Although the Care Act 2014 entitles carers to an assessment of their own needs for support and to have those needs met, lack of funding has made it extremely difficult for local authorities to fulfil those duties.⁴² Financial support to carers is available through the benefits systems: Carers Allowance is £64.60 per week for providing at least 35 hours care to some in receipt of certain disability benefits. The Government has recently launched the Carers Action Plan 2018–20. This sets out a cross-government programme of targeted work to be carried out over the next two years, including work on employment and financial support.⁴³

The workforce

24. The social care workforce is similarly challenged; pay is low, sick pay and pensions are not universal, and vacancy (7.7%) and turnover rates (33.8%) are high—including among nurses working in social care (9% and 32.1% respectively)⁴⁴—leading to a reliance on agency staff.⁴⁵ Zero hours contracts are also prevalent: UNISON estimates that there are more than 300,000 social care workers employed on zero hours contracts across the UK.⁴⁶ We heard of a lack of investment in training and development for care workers,⁴⁷ which was particularly stark when compared to equivalent spending in the NHS,⁴⁸ and of insufficient recognition and status being afforded to their work.⁴⁹ A stable and skilled workforce is essential to the provision of quality care and keeping pace with demand for social care in the coming years—an estimated 500,000 more care workers are needed by 2030.⁵⁰

36 The King’s Fund ([FSC0174](#))

37 [Q2](#)

38 Carers UK ([FSC0143](#))

39 Carers UK ([FSC0143](#))

40 [Q35](#)

41 [Q2](#)

42 Carers Trust ([FSC0069](#))

43 Department of Health and Social Care, [Carers Action Plan 2018 to 2020: Supporting carers today](#), (June 2018)

44 Skills for Care, [Open Access NMDS-SC Dashboards](#) (accessed June 2018)

45 [Q64](#)

46 UNISON ([FSC0096](#))

47 [Q64](#)

48 [Q66](#)

49 [Q64](#)

50 Skills for Care ([FSC0164](#))

Quality

25. The quality of care provided is also suffering. We heard it described as “extremely patchy”,⁵¹ “variable”⁵² and that the care given to people with dementia was often lower quality.⁵³ We note that, overall, the quality of services is good: as at 2 March 2018, over three-quarters (79%, 17,045) were rated Good, and 2% (483) Outstanding.⁵⁴ However, in its written submission, the Care Quality Commission (CQC), the provider quality regulator, also said “there is too much poor care: 2% (348) of services are rated as Inadequate, and 18% (3,799) as Requires Improvement”. They went on to say that, although more services were improving than deteriorating, some were “struggling” to do so which they said “point[ed] to a fragility in the sector that needs to be addressed”.⁵⁵ Caroline Abrahams, Charity Director at Age UK, explained how the challenges in the workforce affected quality: “lack of continuity, never seeing the same person twice [...] rushed visits—maybe quarter of an hour rushing in and out—with no time to establish a proper relationship, let alone real communication”.⁵⁶

Care providers under pressure

26. The funding pressures have flowed through to care providers, who are reliant on local authorities for around 65% of their income.⁵⁷ In recent years, local authorities have provided only small yearly fee uplifts⁵⁸ and, although the introduction of the NLW drove an increase in fees in 2017–18 and 2018–19 of between 3% and 5%,⁵⁹ they are still below the benchmark costs of care.⁶⁰ The Competition and Markets Authority (CMA) has estimated that fees were on average as much as 10% below total cost, equating to “around a £200 to £300 million shortfall in funding across the UK”.⁶¹

27. Care providers are therefore having to absorb the costs of estate maintenance and modernisation, as well as those arising from their responsibilities as employers, which include the Apprenticeship Levy, statutory holiday and pensions and the costs of staff recruitment, training and development.⁶² Furthermore, they now face the risk of having to make backdated payments for underpayment of six years’ worth of sleep-in shifts, estimated by Mencap to amount to £400 million for the learning disability sector alone.⁶³ In consequence, the sector is under extreme pressure, evidenced by the fact that 66% of councils surveyed by ADASS in 2018 had experienced provider failure, which has a serious impact on the many thousands of individuals in their care.⁶⁴ The CQC said that, in 2016, the sector was “approaching a tipping point” and that, in 2017, it “remained precarious”.⁶⁵

51 [Q2](#)

52 [Q64](#)

53 [Q2](#)

54 Care Quality Commission (CQC) ([FSC0171](#))

55 Care Quality Commission (CQC) ([FSC0171](#))

56 [Q2](#)

57 National Audit Office, [The adult social care workforce in England](#), (February 2018)

58 Lifeways ([FSC0131](#))

59 Association of Directors of Adult Social Care, [Budget Survey 2018](#) (June 2018)

60 National Audit Office, [The adult social care workforce in England](#), (February 2018)

61 CMA ([FSC0172](#))

62 Lifeways ([FSC0131](#))

63 Mencap, [Mencap dismayed by Government indecision on funding for sleep-ins](#) (November 2017)

64 Association of Directors of Adult Social Care, [Budget Survey 2018](#) (June 2018)

65 Care Quality Commission (CQC) ([FSC0171](#))

28. Reduced local authority fees have required care providers to top them up or ‘cross-subsidise’ them with the fees of people who pay for their own care. Douglas Cooper, Project Lead at the CMA, said that his organisation had found that the difference in the fees paid by self-funders and local authority funded clients could be “very large—for large operators around 41%”.⁶⁶ This has led to providers becoming increasingly focused on the self-funder market,⁶⁷ resulting in a reduction in services in less well-off areas.⁶⁸ It is notable that, with a lower means test threshold set at £14,250, self-funders are often not wealthy individuals; as John Jackson of ADASS observed “Even quite poor people pay an awful lot for their care”.⁶⁹

A fragile care market

29. Increasing demand combined with provider failure, workforce shortages, deteriorating quality and reliance on self-funders have undermined the stability of the care market. We heard that funding pressures had led to local authorities taking a short-term approach to market shaping and commissioning, and that some commissioning practices—such as reverse auctions—“deliberately drive down the price of care”.⁷⁰ Douglas Cooper of the CMA said that often local authorities’ market shaping plans did not give providers the information they needed to plan ahead and make investments.⁷¹ In addition, we heard that, given the current funding situation, investors were reluctant to invest in care homes for local authority funded residents.⁷² We note that, for the reasons described in paragraph 26, care providers have very little funding to invest in their own assets and expand their service.

Conclusion

30. The combination of rising demand and costs in the face of reductions in funding has placed the social care system under very great and unsustainable strain. In its present state, the system is not fit to respond to the demographic trends of the future. Of greatest concern, is the fact that the very people the system is there to support get only the care they need to survive, rather than the care they need to live full and independent lives. After successive attempts at reform, and in the context of an unrelenting increase in demographic pressures, the social care Green Paper must be the catalyst for achieving a fair, long-term and sustainable settlement.

31. The pressures on social care have also spilled over to the NHS, manifesting themselves chiefly in the form of delayed transfers of care out of hospital and emergency admissions to hospital. These particular pressures, and the interdependencies between the health and social care systems and other services, are discussed in chapter four. Meanwhile the box below discusses the challenges faced by individuals in navigating the system of social care.

66 [Q66](#). See also [Q2](#) [Caroline Abrahams]

67 Buckinghamshire County Council ([FSC0070](#))

68 [Q75](#)

69 [Q130](#)

70 MHA ([FSC0114](#))

71 [Q68](#)

72 CMA ([FSC0172](#))

The challenges faced by the individual: navigating the system

In the preceding paragraphs, we discussed the challenges facing the social care system as a whole. In this text box, we consider the challenges people and families experience in their dealings with the system. They will usually encounter a range of difficult issues, including testing their eligibility for publicly funded social care or continuing health care; the assessment process; care options and choosing a provider; and the costs of care and how to pay for it. From the point of view of the individual, we heard the system described as “almost impossible to navigate”,⁷³ “incredibly complicated”⁷⁴ and “bewilder[ing]”.⁷⁵ This was very much reflected in our focus group discussions with care users, relatives and care home staff at New Deanery Care Home in Braintree. One attendee said to us that finding his way around the system on his wife’s behalf was like “having a jigsaw puzzle with no picture on the box”.

People often approach the social care system at a disadvantage. Unless they have experience of a family member or friend receiving care, they are likely to have little knowledge of how it works. They may be coming to it reluctantly, not wanting to admit they need care and disinclined to seek out advice and information.⁷⁶ They are unlikely to have planned how to meet their care costs, possibly thinking, like many, that social care is free at the point of use.⁷⁷ When confronted with the complexities of the system—often at crisis point after a sudden illness or the loss of a family carer—and the realisation that they are likely to have to pay for care, people are bewildered.⁷⁸ Staff at the New Deanery Care Home told us that “one of the biggest issues is lack of knowledge [...] People come to us not knowing about anything—what they’re looking for, who to speak to”. The Citizens’ Assembly members held the view that the system was “too complex, confusing and misunderstood”.

However, at the point when it is most needed, advice and information can be difficult to obtain. Local authorities should be the first port of call and they are required to establish and maintain an information and advice service.⁷⁹ However, the reality is that the support available varies and is difficult to access.⁸⁰ Although there is good advice available online, the quantity of it and the number of sources can be overwhelming even for people who are adept at using the internet,⁸¹ and many older people are not regular internet users.⁸²

Entry to the publicly funded system is determined by two tests—a process we heard described as a “labyrinth”.⁸³ The needs test determines a person’s eligibility for care by their ability to perform certain tasks, identifying them as eligible where their needs have

73 [Q33](#)

74 [Q77](#)

75 [Q77](#)

76 [CMA \(FSC0172\)](#)

77 [Q77](#)

78 [Q77](#)

79 [Section 4](#), Care Act 2014

80 [Q77](#)

81 [Q77](#)

82 Office for National Statistics, [Internet users, UK: 2018](#) (May 2018)

83 [Q33](#)

a “significant impact on wellbeing”. As their resources have reduced, local authorities have cut back the number of people to whom they provide care by stricter interpretation of the eligibility criteria.⁸⁴

The second test (the ‘means test’) assesses a person’s ability to pay for their own care via income, savings or other assets. The means test and its three thresholds are complex.⁸⁵ And the different rules which apply to residential and domiciliary care, which in the former case require a person’s housing assets to be taken into account but not in the latter, cause confusion and a sense of unfairness. Alongside this, the means tests thresholds for other related services are different which further complicates matters; for example, the means test for the Disabled Facilities Grant takes savings of over £6,000 into account, while eligibility for Continuing Healthcare is based solely on primary health needs. In addition, the threshold levels of the social care means test have not been revised since they were set in 2010–11 and are estimated to be 12% lower in 2018/19 in real terms,⁸⁶ which is perceived to be a source of unfairness.

Once it has been established that a person has care needs, there is little help on offer for them or their family in choosing care. People receiving publicly funded care may have access to a social worker who can advise them on their options and help them find a care home. However, one focus group attendee said that, when seeking help from social services for her mother, she encountered “barrier after barrier”, was “shocked at the lack of help” and was “passed from pillar to post”. Self-funders must usually research care options and make decisions themselves. Many of the residents and relatives at the Braintree focus group fell into this category—one of whom said, “There was no assistance, no guidance about where to go. I just got in my car and went to look”. People who have their care paid for by a combination of public funding and top-up payments also encounter difficulties. Independent Age said that they regularly heard from families “experiencing issues with top-up fees, such as a lack of council involvement, little clarity around who should be paying and questions over value for money”.⁸⁷

NHS Continuing Healthcare (CHC) operates alongside the social care system, adding an additional layer of complexity. CHC, which is arranged and funded by the NHS, provides health and social care to people with significant ongoing health needs, including those at the end of their lives or with long-term conditions, such as dementia. The two-stage assessment process, delays to decision-making and subsequent three-stage appeal process, as well as the significant financial implications for those who are not eligible, means CHC is a source of anxiety and distress for families.⁸⁸ The situation is exacerbated if a person’s needs fluctuate, meaning they can move between receiving free CHC and having to fund their own social care. One focus group attendee whose wife received CHC at the end of her life, described a “gulf between what’s NHS and what’s not—the untold riches of CHC versus means tested social care”.

84 SIGOMA ([FSC0050](#)), Learning Disability England ([FSC0064](#))

85 If a person has assets over £23,250, they are assessed as being able to meet the full cost of their care but if they are below £14,250, they are not required to make a contribution. Those with capital between these two limits are required to make a contribution of £1 per week for every £250 of capital.

86 The Health Foundation and The King’s Fund, [Social care funding options: How much and where from?](#) (May 2018)

87 Independent Age ([FSC0165](#))

88 National Audit Office, [Investigation into NHS continuing healthcare funding](#) (July 2017)

2 Principles for funding social care

32. Agreeing principles can play a valuable role in building consensus on difficult topics, facilitating decision-making and engaging the public in a debate.⁸⁹ For example, following a process of ranking, prioritisation and voting, the Citizens’ Assembly developed a set of values and principles which the members referred to when making their own decisions and recommended should underpin decisions about funding social care.

33. Many of the written submissions we received set out principles which it was suggested should be the foundation for social care reform.⁹⁰ For example, ADASS said that “the debate about how we fund social care should be informed by a clear and coherent set of principles about the purpose of a modern adult social care system and what it is designed to achieve”. Their 12 principles touch on many aspects of the system, from the need for care and support to be centred on the needs and wishes of the individual to funding sufficient for the whole quantum of need, and carers’ rights.⁹¹

34. The Government is also approaching reform in this way. Earlier this year, in March 2018, the Secretary of State for Health and Social Care, Jeremy Hunt, outlined “the seven key principles that will guide the Government’s thinking ahead of the social care green paper”.⁹² Deciding to follow suit, we have developed our own set of principles which have a particular focus on funding. Our principles should build on those already articulated by the Government and inform and direct the forthcoming discussions about how to raise funding for social care and how it should be used. In addition, they underpin the funding recommendations we have set out in chapter three.

The seven key principles outlined by the Secretary of State for Health and Social Care in March 2018 are:

1. Quality and safety embedded in service provision;
2. Whole-person, integrated care with the NHS and social care systems operating as one;
3. The highest possible control given to those receiving support;
4. A valued workforce;
5. Better practical support for families and carers;
6. A sustainable funding model for social care supported by a diverse, vibrant and stable market; and
7. Greater security for all—for those born or developing a care need early in life and for those entering old age who do not know what their future care needs may be.

89 [Q27](#)

90 See, for example, CIPFA ([FSC0060](#)); The Local Government Association ([FSC0049](#)); ADASS ([FSC0116](#)); United for All Ages ([FSC0010](#)); Sense ([FSC0011](#)); Leonard Cheshire Disability ([FSC0101](#)); Inclusion London ([FSC0108](#))

91 ADASS ([FSC0116](#))

92 Department of Health and Social Care, [We need to do better on social care](#) (20 March 2018)

Good quality care

35. In the words of one of our witnesses, “We need to tie any future funding to a genuine conversation about what the system is there to achieve for people and make sure that it really delivers”.⁹³ We agree, and make the further point that funding should be sufficient to ensure that the care provided to people is of good quality, meaning it achieves the aims of social care in promoting a person’s wellbeing, independence and dignity, and their ability to exercise choice and control. This principle was also identified by the Citizens’ Assembly; they wanted a funding solution that would ensure care was high quality, fair and equal and that, in accessing care services, people were treated with respect and there was no postcode lottery. With regards to quality, the Assembly members said:

The funding solution should enable “consistently high quality” social care. Assembly Members stated that “people have a right to quality care” and suggested needing to “increase funding to match the quality of care we want”. To ensure quality, Assembly Members suggested the need for “trained and professional workforce, higher pay, improved inspections, improved assessment [and] increased staffing levels”.

They also said that, alongside more investment in the system, they would expect “a better service”, suggesting that more needed to be spent on the workforce, carers and prevention: “How it is going to be spent is as important as how it is going to be funded.”

36. Principle 1—Good quality care:

Funding should be sufficient to achieve the aims of social care, which are to promote a person’s wellbeing, independence and dignity, and enable them to exercise choice and control over the way their live their life. This will require universal provision of high quality, personalised care delivered by a stable well-paid and well-trained workforce alongside well-supported carers to a wider group of people than currently receives care, all within a navigable and accessible system. It should also aim to address the current levels of unmet and under-met need.

Considering working age adults as well as older people

37. The Green Paper will focus solely on social care for older adults, with policy on social care for working age adults to be developed through a “parallel process”.⁹⁴ We heard this division strongly contested by organisations representing working age adults with care needs, as well as those representing older people.⁹⁵ Neil Heslop, Chief Executive of Leonard Cheshire, which represents working age adults, said “There is real concern that splitting [the groups] risks not delivering an outcome for both communities appropriately”.⁹⁶ The Citizens’ Assembly members also had a strong preference for joining up the social care reform process for working age adults and older people.

93 [Q19](#)

94 HC Deb, 16 November 2017, [col16WS](#) [Commons written ministerial statement]

95 For example, Caroline Abrahams at [Q9](#)

96 [Q7](#)

38. **Principle 2—Considering working age adults as well as older people:**

The social care Green Paper is focusing on older people. However, provision of care for working age adults amounts to over half of all spending on social care and is set to grow in future years. To be sustainable, reforms to social care funding, including decisions on where the funding should come from, need to take into account the costs of meeting the needs of working age adults. At the very least, the Green Paper should be closely linked with the parallel programme for working age adults, clearly setting out how its proposals impact on funding for that age group. The Green Paper should consider both.

Ensuring fairness between the generations

39. The evidence we heard revealed that, for a funding solution for social care to be perceived as fair across the generations, it would have to reconcile different attitudes across the age groups. These included the feeling among older people that they had “worked hard during their lives, paid their taxes, paid into the system and it ought to be there for them when they need it in later life”.⁹⁷ On the other hand, while recognising that not all older people are wealthy, in general older people’s wealth relative to younger generations was seen as having increased in recent decades,⁹⁸ with the current generation of young people being “the first to be worse off than their parents”,⁹⁹ with many facing an extended period of paying in effect a “graduate tax”.¹⁰⁰ The further point was also made that, as older people will benefit from social care reforms, “it would be reasonable to expect [them] to make some contribution”.¹⁰¹

40. **Principle 3—Ensuring fairness between the generations:**

Intergenerational fairness needs to be addressed. Contributions towards the cost of care should be fairly distributed between generations. Some older people who stand to be the main beneficiaries of increased spending on social care may be relatively wealthy, with housing assets, savings and pensions, compared to younger generations. Young people often face higher housing costs, less stable employment and less generous pensions, and may be paying back student loans or have family commitments. Life expectancy has increased, which is a cause for celebration, but which again has implications for the balance of contributions between different age groups. Working age employed adults are a shrinking proportion of the total adult population. For these reasons, older people could be expected to continue, while taking into account the fact that they have contributed throughout their working lives via taxation. However, over the longer term, the distribution of wealth between the different age groups may change, with corresponding implications for fairness, suggesting that a flexible solution is required.

97 [Q19](#). See also [Q46](#)

98 CIPFA ([FSC0060](#))

99 United for All Ages ([FSC0010](#))

100 [Q20](#)

101 [Q43](#)

Aspiring over time towards universal access to personal care free at the point of delivery

41. Currently, the greater part of the burden of the costs of care is shouldered by individuals. For dementia sufferers, who can face care costs of £100,000 to £500,000,¹⁰² this results in great unfairness, particularly when other long-term health conditions, like heart disease or cancer, are treated within the NHS free of charge. Dominic Carter of the Alzheimer’s Society told us that “We need to move to a point where the balance of responsibility is clearer [...] but is also fairer between the individual and the state”.¹⁰³ The Dilnot Commission recommended a more generous means test and a cap to divide the costs of care more fairly between older people and the state and that individuals who enter adulthood with care needs should receive free state support (a ‘zero cap’). This approach was accepted in principle by the then Government and legislated for in the Care Act 2014, but the relevant part of the Act has not yet been implemented.¹⁰⁴ The Citizens’ Assembly wanted to go further than this; two thirds of the members voted for an entirely publicly funded system as their first preference, and we set out their reasons for this conclusion in chapter four. While this would of course substantially increase costs, we believe that it should be the aspiration for social care in the long term and that this principle should be borne in mind when considering future funding. In the short term we feel that at least those assessed as having critical need for social care should receive this free at the point of delivery.

42. Principle 4—Aspiring over time towards universal access to personal care free at the point of delivery:

Currently, the burden of the cost falls on individuals in an unfair distribution depending on diagnoses—particularly those paying for dementia care, the costs of which can be extremely high. The balance needs to be redressed, aspiring over time and moving towards, as funding permits, universal access to sustainably funded social care, free at the point of delivery.

Risk pooling—protecting people from catastrophic costs, and protecting a greater portion of their savings and assets

43. Currently people who have high social care needs can face catastrophic care costs—there is currently no way of insuring yourself against these risks. A more generous means test (or ‘floor’) and a cap would divide the costs of care more fairly between older people and the state. These mechanisms would also protect people from catastrophic care costs and protect a greater proportion of their savings and assets. Providing free at point of delivery care for those with high care needs would be another way of protecting people from this risk.

102 [Q2](#)

103 [Q14](#)

104 Department of Health and Social Care, [Letter from Alistair Burt to Izzi Seccombe](#) (17 July 2015)

44. Principle 5—Risk pooling—protecting people from catastrophic costs, and protecting a greater portion of their savings and assets:

People want to be protected from the lottery of incurring catastrophic care costs, and to feel secure that they will be able to keep a greater proportion of their savings and assets. A cap on the amount of care costs a person paid would pool the risk, distributing the costs of very high care needs across the society. The level of protection (and therefore the costs of this policy) would depend on the level at which the cap is set, and determining this figure requires financial modelling and extensive consultation. Raising the means test threshold (the ‘floor’) is another way of enabling people to keep a greater proportion of their assets; again, the costs would be shared across society. Providing free at point of delivery care for those assessed as having critical or substantial care needs would be another way of protecting people from this risk.

‘Earmarked’ payments

45. ‘Hypothecation’—or ring-fencing taxation to a specific purpose—is often proposed as a way of raising more funding for social care. We prefer to use the more easily understandable term ‘earmarking’. While tax rises are generally not popular with the public, clearly linking them to a specific purpose can build support and acceptance for them.¹⁰⁵ The views of Citizens’ Assembly members, two thirds of whom voted for additional social care funding to come from earmarked taxation as opposed to general taxation, reflected this. However, the weaknesses of this approach should also be borne in mind. If the ring-fence is rigidly drawn, the tax take will rise and fall with the economy over time and not be aligned with changes in need or demand. However, any degree of flexibility risks the revenue not being used for its original purpose—we note the examples of earmarked taxes which have been introduced for a specific purpose but have later been subsumed into the pool of general taxation, for example, Vehicle Excise Duty and National Insurance.

46. Principle 6—‘Earmarked’ payments:

People are generally willing to contribute more to pay for social care if they can be assured that the money will be spent on this purpose. ‘Earmarking’ taxation can help to give confidence and accountability over spending.

3 Options for funding social care

How much funding is needed?

47. There is widespread agreement that more funding is needed for social care. However, deciding how much should be raised and how it should be spent is less straightforward. Meeting future demand is one consideration. Others include more ambitious reforms, including ensuring funding for good quality care, introducing free personal care, a cap on care costs and raising the means test threshold (or ‘floor’). We consider what each of these reforms might entail, and their costs, in the paragraphs below.

Meeting future demand

48. The demographic trends discussed previously will continue to exert pressure on social care services in the long term with corresponding implications for funding. The Office for National Statistics’ population projections show that the number of people aged 65 or over is expected to increase from 12.2 million (18% of the population) in 2018 to 16.7 million (23%) in 2033.¹⁰⁶ Growth in older age groups is expected to outstrip growth in younger age groups: in 2033, there are expected to be 4.4 million more people aged 65 and over in the UK population, but just 1.5 million more under-65s.

49. The Personal Social Services Research Unit (PSSRU), a research group at the London School of Economics, has produced long-term care projections specifically with a view to informing discussion about future demand for and costs of adult social care. They have created models of activity and funding based on the current system in England which are used by the Department of Health and Social Care and the Office for Budget Responsibility (OBR). Their projections show that, between 2015 and 2040, the numbers of disabled older people will rise by 67%, and the number of older people with more severe disability will rise by 69%.¹⁰⁷ For younger adults, the PSSRU draw on projections by Emerson which show that the number of younger adults with learning disabilities receiving local authority home care or direct payments will rise by 72.5% between 2015 and 2040 and that the number in local authority funded residential care will also rise by 72.5% during that period.¹⁰⁸

50. At the same time, chronic conditions, which place demand on both health and social care services, are on the increase. The Institute for Fiscal Studies (IFS) and the Health Foundation estimate that the number of people living with a single chronic condition has grown by 4% a year, while the number living with multiple chronic conditions grew by 8% a year between 2003–4 and 2015–16.¹⁰⁹ They link these rises to physical inactivity, poor diet, smoking and alcohol consumption, noting that increasing obesity levels have possibly offset falling smoking rates. ‘Multi-morbidity’ is also increasing: between 2015 and 2035, the proportion of people with four or more diseases will almost double, rising from 9.8% in 2015 to 17.0% in 2035.¹¹⁰

106 Office for National Statistics, [ONS 2014 principal projections – UK: 2014 based](#) (2017)

107 Wittenberg, Hu, Hancock, [Projections of Demand and Expenditure on Adult Social Care 2015 to 2040](#) (June 2018)

108 Emerson E, Robertson J, Coles B, Hatton C, [Estimating the Need for Social Care Services for Adults with Disabilities in England 2012–2030](#) (2012)

109 Institute for Fiscal Studies and The Health Foundation, [Securing the future: funding health and social care to the 2030s](#) (May 2018)

110 Kingston, Robinson, Booth, Knapp, and Jagger, [Projections of multi-morbidity in the older population in England to 2035: estimates from the Population Ageing and Care Simulation model](#) (2018)

51. The PSSRU's projections of demand for and costs of social care were frequently referenced in the evidence we received, and have been used in recent studies to calculate the potential costs of different social care funding options.¹¹¹ The Unit has recently updated its projections. They project that that, at constant 2015 prices and under a set of base case assumptions about trends in the drivers of long-term care demand and in the unit costs of care services, public expenditure on social services for older people is projected to rise under the current funding system from around £7.2 billion (0.45% of GDP) in 2015 to £18.7 billion (0.73% of GDP) in 2040. They also project that public expenditure on social services for younger adults will rise under the current funding system from around £8.9 billion (0.55% of GDP) in 2015 to £21.2 billion (0.83% of GDP) in 2040.¹¹²

52. Based on the PSSRU's estimates, the IFS and the Health Foundation have estimated that maintaining social care services at 2015–16 levels would require spending to increase by a projected 3.9% a year over the next 15 years.¹¹³ In addition, the OBR has made its own assessment of the increasing need to spend on social care. They state that “if governments choose to increase spending on health and social care to accommodate long-term cost and demand pressures—a plausible interpretation of unchanged policy—then spending would rise gradually but significantly over coming decades as a share of GDP”. In its 2017 Fiscal Risks Report, the OBR estimated that spending would rise from 1.1% of GDP in 2021–22 to 2.0% of GDP in 2066–67.¹¹⁴

53. In addition, we note the estimate provided by John Jackson of ADASS who estimated that the need to spend on social care (older people and working age adults) could double by 2020 (local authorities' net expenditure on social care in 2017–18 was £14.8 billion).¹¹⁵ He explained how he arrived at this much higher figure:

You start with the £2 billion a year that we need by 2020 [...] Then I am saying the pressures every year are an extra £800 million. In the first year it is £800 million and the second year it is £1.6 billion. After 10 years that totals £8 billion extra that you need to spend a year by 2030. I am also suggesting that if you want to improve care workers' wages—and we would strongly support that—then you need quite a significant injection of money direct to those care workers. If you were to put up wages by 29%—and I have chosen 29% because that is what the lowest paid staff in the recent NHS settlement are going to get—then that will probably cost about £3 billion a year. I have to say that this is quite rough and ready; it is not scientific. There is an argument for having a much more scientific piece of work, but I would be very surprised if they came up with a figure that was significantly different from doubling the spending on adult social care, and that is just to let the current system carry on as it is now.¹¹⁶

111 For example, by the Care and State Pension Reform (CASPeR) project and The King's Fund and The Health Foundation

112 Wittenberg, Hu, Hancock, [Projections of Demand and Expenditure on Adult Social Care 2015 to 2040](#) (June 2018)

113 Institute for Fiscal Studies and The Health Foundation, [Securing the future: funding health and social care to the 2030s](#) (May 2018)

114 Office for Budget Responsibility, [Fiscal Risks Report](#) (July 2017)

115 [Q113](#)

116 [Q116](#)

54. We note, however, the difficulties inherent in forecasting need.¹¹⁷ We heard that there was therefore a need for regular independent forecasts of needs and funding requirements¹¹⁸ and that an independent body, like the OBR, should be tasked with this function.¹¹⁹ We note the recommendation made by the House of Lords Committee on the Long-term Sustainability of the NHS for an independent ‘Office for Health and Care Sustainability’ to advise on all matters relating to the long-term sustainability of health and social care including demographic trends, disease profiles, workforce and skills mix and funding, looking 15–20 years ahead.¹²⁰ The CMA has also recommended that an independent body should be established to advise the Government on the costs of providing different types of care and provide data to local authorities to help them plan to meet local need for care, as well as overseeing their commissioning practices.¹²¹

Funding good care

55. The estimates we received indicate likely future expenditure on care if current policies are unchanged. However, as discussed in paragraphs 21 to 29, the care currently provided is falling well short of being good care—the sector is struggling to meet need and maintain quality in the context of rising demand, constrained budgets, a fragile provider market and a workforce under pressure. The amount of funding needed to ensure that care is of better quality in the future is therefore likely to be significantly higher. In accordance with the first of our principles for future social care, articulated above, we very much agree with Professor Martin Green, Chief Executive of Care England, who said that, when determining funding for social care, “we need to start from the basis of saying what it costs to provide good quality care, which is about giving people a life”.¹²²

56. Our witnesses described what might be considered when determining what good care consists of. Andrea Sutcliffe, Chief Inspector of Adult Social Care at the CQC, said:

[It] has to be thinking about what are the needs that people have in their local communities and in the specific services, but also how we ensure that that is a service that meets their needs and aspirations, because we do not want people to be fearful of using adult social care services. We want them to see that as a positive thing that will help them to live the life that they want to live.¹²³

Martin Green of Care England said:

It has to be very much focused on that positive approach that enables people to be as independent as possible, and services should be focused on that and maintaining people at the highest level of independence they can possibly have. It needs to be a preventive strategy as well as a service strategy. People need lives, not a series of services.¹²⁴

117 [Q41](#)

118 [ADASS \(FSC0116\)](#)

119 [The King’s Fund \(FSC0174\)](#). See also [Q60](#)

120 [House of Lords Select Committee on the Long-term Sustainability of the NHS, HL Paper 151, Report of Session 2016–17, The Long-term Sustainability of the NHS and Adult Social Care](#) (April 2017)

121 [CMA \(FSC0172\)](#)

122 [Q81](#)

123 [Q70](#)

124 [Q70](#)

Anna Bird of Scope suggested that “talking in real language about what disabled people and older people want” would help to set out what was expected of social care and enable it to be funded accordingly.¹²⁵ Finally, we note the suggestion made by Sarah Pickup of the LGA that the Care Act 2014 was a starting point as “a good basis for setting out what we are all aspiring to do for people [...] quality, innovation and focusing on wellbeing and prevention. All those things are [its] aspirations”.¹²⁶ This legislation commanded wide support, not only for its provisions but also for the extensive consultation undertaken with the sector in its preparation.¹²⁷

57. Determining the costs of good care will also require consideration of the level of pay needed to maintain a quality workforce and recruit and retain care workers and social care nurses. We heard that this may necessitate benchmarking the wages paid in the care sector against those in the NHS.¹²⁸ John Jackson of ADASS pointed out that, in the forthcoming NHS settlement, the wages of some of the lowest paid staff in the NHS could increase by 29%, which he calculated would cost around £3 billion a year if applied to care workers’ wages.¹²⁹ We note that recruiting, training, nurturing and retaining the workforce is key to the delivery of high quality social care.

58. In summary, and based on the challenges identified in paragraphs 21 to 29, in order to fund genuinely ‘good’ care, an assessment will need to be made of the costs required to:

- Meet people’s needs for care and support in a way which enables them to live a full and independent life;
- Provide preventative services and intervene early to prevent people’s needs growing;
- Assess unpaid carers and meet their own needs for support, including provision of reliable and good quality respite care;
- Properly remunerate and ensure the employment conditions of care workers—in line with UNISON’s ethical care charter¹³⁰—and provide them with training, qualifications and opportunities for career development, all of which are needed to stabilise the workforce and encourage its growth;
- Enable care providers to meet their costs, invest in their assets and expand their offer, in turn ensuring the stability of the care market;
- Enable improved collaborative working between health and social care professionals through initiatives such as care coordinators and better use of digital technology and enabling people to hold and share their own medical and social care records across systems; and
- Make use of the role of housing in supporting health, wellbeing and independence.

125 [Q28](#)

126 [Q102](#)

127 [Q21](#). See also ADASS ([FSC0116](#))

128 [Q85](#)

129 [Q116](#)

130 UNISON, [UNISON’s ethical care charter](#)

Reforms

59. Defining and costing good care is an essential prerequisite to funding decisions on social care. Beyond this, proposals for more fundamental reforms of the social care system aim primarily to protect people from catastrophic care costs in different ways. Introducing a cap on the total amount an individual would have to pay, in conjunction with raising the means test threshold, was proposed by the 2011 Commission on the Funding of Care and Support¹³¹ and legislated for in the Care Act 2014 (but not implemented), with a modified version of these plans proposed in the Conservative Party manifesto last year. Making certain elements of social care free at the point of delivery to people with different levels of need is another way of reducing the risk of catastrophic care costs falling on individuals—in Scotland, free personal care was introduced in 2002,¹³² and the Barker Commission advocated a similar approach in England in 2014.¹³³ As the text box below shows, there has been a long history of proposals to introduce both of these types of reforms, sometimes in conjunction with each other:

Past proposals for reforming social care funding [Source—House of Commons Library]¹³⁴

- 1999, March—the Royal Commission publishes its report:
 - recommendation of free personal care (following assessment of needs) funded by general taxation;
 - recommendation of a more generous means-test of £60,000 in 1999 prices (about £95,500 in 2016 prices) in respect of people funding their care relating to living costs and housing;
 - the idea (although not recommended by the Commission) of a four-year cap on paying social care charges;
- 2000, July—the Government published its response in which it:
 - rejected the idea of free personal care;
 - updated the main means-test parameters to take account of inflation, but did not implement the Commission’s proposal for a significantly more generous means-test;
 - gave no response to the cap idea;
 - accepted a number of other proposals by the Commission, including free NHS nursing care for care home residents, and a three-month disregard of the value of the home for those in care homes;
- 2000, October—the Scottish Executive rejected the proposal for free personal care;

131 Also referred to in this report as the ‘Dilnot Commission’.

132 See text box below for details.

133 Commission on the Future of Health and Social Care in England, [A new settlement for health and social care](#) (September 2014)

134 House of Commons Library Briefing [Social care: Government reviews and policy proposals for paying for care since 1997 \(England\)](#), (October 2017)

- 2001, January—the Scottish Executive accepted the proposal for free personal care, which was implemented in Scotland from July 2002;
- 2006—Sir Derek Wanless’s report, commissioned by the independent King’s Fund, proposed a move to “partnership” funding for social care;
- 2009, July—the Government published a Green Paper proposing that a “National Care Service” be established;
- 2010, March—the Labour Government’s White Paper proposed a two-year cap on paying for social care from 2014, and free-at-the-point-of-use social care for everyone at an unspecified point after 2015, with an independent commission to be established to consider how the policy should be funded;
- 2011, July—the Commission published its report, and its recommendations included:
 - a £35,000 lifetime cap for paying for social care for over 65s;
 - a lifetime cap of zero for anyone who either entered adulthood with an existing care and support need, or who developed an eligible need before 40 years of age;
 - a lifetime cap of zero for anyone who had been in residential care for at least two years b a more generous means-test, with a new upper limit of £100,000, but the lower limit remaining at £14,250;efore the cap was introduced;
 - a more generous means-test, with a new upper limit of £100,000, but the lower limit remaining at £14,250;
 - a standard rate for services other than social care provided in a care home (e.g. accommodation, food) “in the range of £7,000 to £10,000 a year”;
- 2012, July–2015, February—the Government develops its response, including:
 - a £72,000 lifetime cap on social care bills for all adults over 25;
 - a zero cap for life for people turning 18 with eligible care and support needs or developing eligible needs up to the age of 25;
 - only social care costs incurred after the cap was introduced to count as progress towards the cap;
 - the amount a local authority would have paid for social care to count towards the cap, rather than the actual amount a person had paid;
 - a more generous means-test with an upper limit of £118,000 for those whose home is included in the means-test or “around” £27,000 for those whose home isn’t, and the lower limit increased to “around” £17,000;

- a standard contribution to daily living costs of £12,000 per annum for those care home residents with capital less than the appropriate upper limit;
- reforms to be introduced in April 2016;
- 2015, April—a number of reforms introduced including:
 - universal deferred payment arrangements;
 - new support for carers;
 - a new national level of care and support needs to make care and support more consistent across the country;
- 2015, July—the Government announced the postponement of the introduction of the reforms, including the cap and more generous means-test, until April 2020;
- 2017, May—during the General Election, the Conservative Party stated it would publish a Green Paper to include proposals on social care funding reform, which will include:
 - “an absolute limit on what people need to pay”;
 - a single £100,000 limit in the means-test;
 - the value of the home to be included in the means-test for those in receipt of domiciliary care; and
 - the extension of deferred payment arrangements to those receiving domiciliary care. (Later a cap at unspecified level was added to these proposals)

Cap and floor model

60. Our written evidence revealed a variety of views on the cap and floor. Some organisations opposed it on the basis that it would mainly benefit wealthier families¹³⁵; others highlighted the perceived increase in bureaucracy.¹³⁶ Others felt that raising the ‘floor’ or means test was fairer than introducing a cap, pointing to the Welsh model where the means test has recently increased to £40,000, without the introduction of a cap, as the same level of assets is protected however much money you have.¹³⁷ However, there was strong support from some, including Care England, a body representing care providers:

The most recent reforms of adult social care set out in the Care Act 2014 and the associated Dilnot Review encapsulated a thorough examination of how to ensure a sustainable care system and put in place the legislative framework to deliver these reforms. The government undertook a wide-ranging consultation process and worked closely with the sector in co-producing solutions to the challenges and opportunities being faced by

135 For example United for All Ages ([FSC0010](#))

136 For example Professor Luke Clements ([FSC0015](#))

137 For example Mr Trevor Durham ([FSC0074](#))

individuals, families, carers, care staff, providers and commissioners across the system, and it feels entirely counter-intuitive to re-run this all over again and risk further escalation of a situation already at a tipping point. Rather, Care England would encourage the Government to fulfil its previous public commitments to introducing the Care Cap and Threshold and utilize the legislation that is sitting in the stocks ready to go.¹³⁸

61. The King's Fund and Health Foundation provide the following commentary on the Conservative manifesto funding options for social care their recent analysis:

The inclusion of a cap on care costs and the proposed changes to the means test are likely to mean a more generous system for some, offering protection against catastrophic care costs. This option constitutes a policy that has previously received some support from across the political spectrum. However, there is a question as to whether this alone is the best use of increased spending on social care, given the complex pattern of 'winners' and 'losers' (some of whom will make big gains)

In principle, a cap on care costs would protect people from very high costs of care. However, the extent of this protection (and naturally, the cost to the Treasury) would depend entirely on where the cap was set. Even with the introduction of a cap and a floor, many people would still be liable for relatively high costs—including all care which falls outside of needs eligibility.

There is a risk that including property in the means test for domiciliary care would reduce the incentive for people to remain in their homes (although it is difficult to predict how behaviours would change in practice). This may be seen by many as unhelpful, given that current health and care policy is aimed at supporting people to live independently, and avoiding the need for long-term care as far as possible. Implementation of this system would be aided by the fact that some of the principles set out by the Dilnot Commission, such as a cap on costs, are already provided for through the 2014 Care Act. However, communicating this system—which has added complexity—to the public is likely to be difficult, given the limited understanding of the current system. It will, in practice, also be a very different system, with vast numbers of deferred payments perhaps becoming the norm.

As this offer is more generous to potential residential care users, there is a risk that it could create additional demand for residential care versus domiciliary care, running contrary to the long-term strategic direction of most local authorities.¹³⁹

62. Sir Andrew Dilnot explained why a cap would reassure people: "Until a cap is introduced, the population as a whole faces no opportunity to pool its risks, so everybody is facing what is, I think, terrifying for them".¹⁴⁰ The Citizens' Assembly members, when asked about different options for a means test and cap, felt that if people were funding

138 Care England (FSC0048)

139 The King's Fund and the Health Foundation, [A fork in the Road - next steps for social care funding reform](#), (May 2018)

140 [Q54](#)

their own care, a cap was important, with more than three quarters voting for the most generous option of £50,000. They felt a cap would “enable people to know where they stand”, “reduce anxiety” and “encourage people to save”. They also voted for a rise in the floor:

In discussion, Assembly Members felt that the current band—£14,250 to £23,250 assets—was too low. Some Assembly Members felt that a high ‘floor’ was important to incentivise people to save and that the ‘floor’ should increase over time to take account of rising costs.

Similar sentiments with regards to both the cap and floor were expressed by the people we spoke to during our focus group at New Deanery Care Home.

63. The difficulties inherent in determining the level at which a cap should be set were highlighted in the evidence we received,¹⁴¹ as were the administrative costs of introducing a cap.¹⁴² Independent Age said that their research had indicated that the £72,000 cap on care (but not accommodation) costs¹⁴³ would have been “of limited value [...] impact[ing] only 1 in 10 of those who currently pay for their own care” and that a £100,000 all-inclusive cap would be more effective.¹⁴⁴ We also note that the level at which the means test threshold is set can affect an individual’s incentive to save.¹⁴⁵ Whether the value of a person’s house is drawn upon to pay for their social care is a contentious issue. The Citizens’ Assembly members were asked to vote on this issue and their strong preference was that the value of a person’s house should not be included in the calculation of assets:

In discussion, Assembly Members felt that including the ‘family home’ in asset calculations was “not fair” and penalised home owners, with suggestions that it is a “tax on a lifestyle choice” and concern that “you are encouraged to buy, but then it is taken away—why bother?”. However, there were some Assembly Members who considered including housing to be the fairer option, as “property is an asset like any other savings” and “people with more pay more”. Some Assembly Members suggested that while the main ‘family home’ should be excluded, additional homes should be included.

Assembly Members also had some pragmatic reasons for favouring excluding housing. There was a concern that the inclusion of housing assets created “perverse incentives” with “people denying themselves help” and “stopping wanting care because the house will go”. Assembly Members also suggested including housing encouraged “fiddles” where house ownership is transferred. There was also concern about the sustainability of the system, with fewer people being able to afford to buy homes today as compared to previously, and the use of equity release schemes meaning that older people may no longer own their whole home.

141 Independent Age ([FSC0165](#)) and County Councils Network ([FSC0118](#))

142 Professor Luke Clements ([FSC0015](#))

143 The Dilnot Commission recommended a £35,000 cap on care costs. The Government responded by committing to a £75,000 cap, which was subsequently reduced to £72,000.

144 Independent Age ([FSC0165](#))

145 Institute and Faculty of Actuaries ([FSC0126](#))

Free at point of use social care

64. Witnesses described the fact that NHS care is free at the point of delivery and social care is heavily means tested as ‘an historical accident’.¹⁴⁶ As discussed previously, as well as means testing, access to publicly funded social care is also determined by eligibility criteria relating to a person’s level of need, which have been tightened in recent years. The result has been an increase in people self-funding, and in unmet need, potentially amongst those with little means, who would previously have qualified for local authority funded social care, but whose needs now fall outside eligibility criteria.

65. Many previous proposals for reform have also suggested making all, or different aspects, of social care free at the point of delivery. This includes proposals for free ‘personal care’,¹⁴⁷ which includes personal hygiene, continence, diet, mobility, counselling, simple treatments and personal assistance, but not the cost of accommodation, food and living expenses for people in residential care.¹⁴⁸ However, Leonard Cheshire Disability point out that ‘personal care’ is itself a restrictive definition of social care and argue in favour of lowering the eligibility criteria from ‘substantial’ to ‘moderate’:

Social care should be holistic and extend beyond ‘personal care’. There needs to be greater support for preventative measures that empower disabled people to live full and independent lives in their communities whether through volunteering, learning or employment opportunities. This will ensure a more sustainable social care system for the future ... The government should lower the eligibility criteria from ‘substantial’ to ‘moderate’ to ensure all disabled people who need care receive it.¹⁴⁹

66. Many commentators expressed the view that if we were beginning with a ‘clean sheet of paper’, it is unlikely that we would design the current system of divisions between health and social care. Caroline Abrahams of Age UK described the situation as follows:

... the first thing you have to say to people is, “You have to pay for some things and not for others.” Explaining the rationale for that—and dementia is a very good example—is really difficult, because, largely, these are historical accidents. I think most people agree that if we were starting again—if we did not have what we have now—we would have a fully joined-up system from the start and we would be funding both in the same way rather than separating them off. What has happened over time is a social construct. Some things you now have to pay for that are called social care used to be called health some years ago and are called health in some other countries. We have reached where we are through a whole range of decisions made by Governments over a long period.¹⁵⁰

Simon Stevens, Chief Executive of NHS England, also highlighted the inconsistencies between eligibility for public funding for different aspects of health and care:

146 [Q28](#) [Caroline Abrahams]

147 Personal care tasks are defined as personal hygiene tasks (shaving, cleaning teeth), eating requirements (food preparation), mobility assistance, medical treatments (administering creams and medications), and attending to general wellbeing (dressing, getting in and out of bed).

148 These costs are sometimes referred to as ‘hotel’ costs.

149 Leonard Cheshire Disability ([FSC0101](#))

150 [Q28](#)

So we have very significant funding streams, each with different, arguably cross-cutting or contradictory eligibility criteria. Without in any way understating the complexity of a form of coherence or streamlining, that would appear to be important in any durable medium-term answer.¹⁵¹

67. Continuing Healthcare (CHC) funding provides a very clear illustration of the difficulties that emerge when there is a hard boundary between health and social care. Participants at our focus group in Braintree talked compellingly about their experiences of negotiating CHC funding, describing long waits to get decisions, and long waits for the outcomes of appeals, and the ‘gulf’ that lies between:

A gulf exists between what’s NHS and what’s not—the untold riches of CHC versus means tested social care. I would rather we were honest and say, “There’s not enough money”. My wife was finally granted CHC funding in the last two weeks of life when she was completely bedridden and unable to do anything. It’s partly that dementia is such an enormous social problem that there is simply not enough funding to treat it as a disease. If it were cancer, there would be no question about the funding for it.

Sarah Pickup of the LGA, reinforced this view, saying “it does not make sense, particularly in a care home setting, where one minute you are paying for your full care and the next you are paying for nothing”.¹⁵² The NAO recently conducted an investigation into CHC funding, prompted by a large number of public complaints. They concluded that there is significant variation across the country in both the number and proportion of people assessed as eligible for CHC, which cannot be fully explained by local demographics or other factors, suggesting that clinical commissioning groups and local authorities are interpreting the assessment framework differently. They also reported significant delays in assessments, which cause considerable distress to patients and families, as well as contributing to delays in discharging patients from hospital.¹⁵³

68. These complexities and inconsistencies were amongst the reasons members of our Citizens’ Assembly gave for supporting a move to a system where all social care is free at the point of delivery. The current system was seen by members to be “complex, dysfunctional and underfunded”:

Assembly Members were particularly concerned to have “one set of rules for all” and to avoid “artificial distinctions” which result in people with some conditions (e.g. dementia) facing much higher costs than others (e.g. cancer). Assembly Members discussed whether some types of care should be moved to being free at the point of delivery; for example, making personal care free, but continuing to charge for “hotel” costs. Despite having some reservations about the cost of making social care free at the point of delivery, it was favoured because it would “be more fair”, “help with prevention” and require “less assessments” (which Assembly members saw as a costly process).

The need to address the complexities of the current system was also reflected strongly in the values and principles identified by the Citizens’ Assembly, which included ‘easily accessible’ and ‘simple and clear’:

151 [Q161](#)

152 [Q135](#)

153 National Audit Office, [Investigation into Continuing Healthcare Funding](#), (July 2017)

Assembly Members felt that people accessing services “shouldn’t have to fight for care” and that the system should provide ‘solutions rather than obstacles’ ... the funding solution should create ‘clarity in the system of social care’ and make it ‘more simple’. Assembly Members also suggested the need for ‘honesty and transparency’ in the system.

The Scottish social care system [Source—the King’s Fund and Health Foundation]¹⁵⁴

Free personal care has been offered in Scotland since 2002. Under this model in Scotland, personal care is provided to anyone aged over 65 based solely on need and not their ability to pay. Personal care includes personal hygiene, continence, diet, mobility, counselling, simple treatments and personal assistance. Those at critical or substantial risk to their independence or health and wellbeing are expected to be provided with social care services within a short period of time.

The approach is different depending on whether the individual receives personal care in their own home (domiciliary care) or in a care home.

People receiving domiciliary care are not charged for any personal care services. The package offered varies on a case-by-case basis. According to free personal care data, net spending on domiciliary care services for older people in 2015/16 was £196 per week per user in 2018/19 terms: of this £161 was spent on free personal care.

For people who receive care in a residential home, the local authority contributes to the cost of their personal care (at a flat rate) directly to the care provider. As of April 2015, this contribution is £171 for personal care, plus an additional £78 per week for nursing care services if needed. This payment does not cover accommodation costs, which are subject to a means test. This is currently mandated by the Scottish government, so cannot vary across different local authorities.

The model has proved popular and durable in Scotland and is now being expanded to adults of working age. The number of people in receipt of personal care grew significantly once the policy was introduced, suggesting that the system is providing care for people whose needs were previously unmet.

The system also supports the longer-term vision for social care (and health) more broadly, by supporting older people to stay in their own homes. However, introducing free personal care also appears to have reduced the provision of care services which do not meet the narrow definition of personal care in fixed budgets, and charges have increased. The needs-based system avoids the boundary between NHS and social care that exists in England. However, because there are no graded levels of support, there is a ‘cliff edge’ for those with needs just below the threshold, and currently for those under 65 (although the system is due to be extended to people under 65). In Scotland, the introduction of free personal care also appears to have resulted in increases in charges for other types of social care, for example help with shopping or housework. The principle of a needs-based system is easy for users to understand. However, there is some complexity around the definition of ‘personal care’, with different local authorities in Scotland interpreting the legislation differently. The

¹⁵⁴ The King’s Fund and the Health Foundation, [A fork in the Road - next steps for social care funding reform](#), (May 2018); The Health Foundation and The King’s Fund ([FSC0145](#))

Scottish experience of implementing free personal care highlights a number of issues, including the administrative burden involved in determining the split between personal and non-personal tasks for all service users.

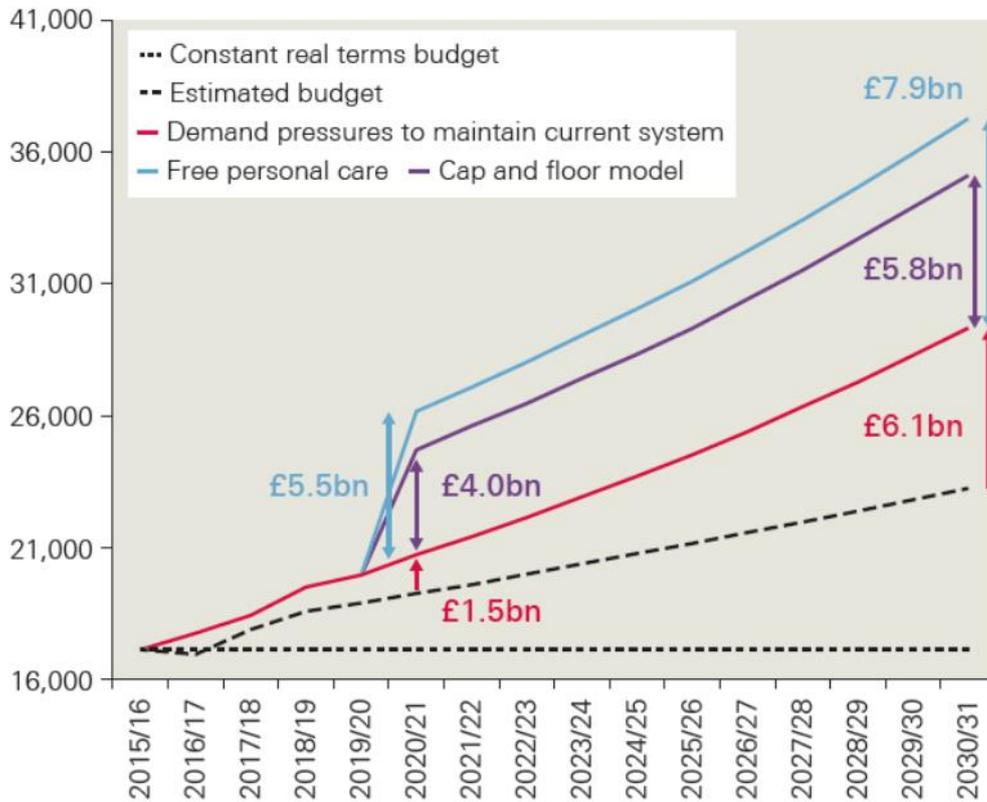
Local authorities in Scotland experienced a loss of income and an increase in costs when free personal care was introduced, and the system has become increasingly expensive over time. However, analysis suggests that—by supporting older people to live at home, helping prevent costly hospital admissions, and delaying the need for residential care—the system may have resulted in lower total government expenditure as compared with no policy being in place.

The cost of reform

69. Modelling the costs of the different reform options is complex and, at best, inexact. The King's Fund has modelled the potential costs of reforms to social care funding for over 65s. They have estimated that a cap and floor model (with the cap set at £75,000 and the floor at £100,000) would cost an additional £5 billion per year in 2020–21 and an extra £12 billion in 2030–31, and that, at current levels of eligibility, free personal care would cost an extra £7 billion in 2021 and £14 billion by 2030–31. The most expensive option is to improve quality and eligibility back to the levels that the King's Fund suggest were provided eight to nine years ago, which increase from £8 billion per year to £15 billion per year by 2031.¹⁵⁵

155 The King's Fund and the Health Foundation, [A fork in the Road - next steps for social care funding reform](#), (May 2018), p20

Figure 1: Costs for the cap and floor model and free personal care alongside additional costs for maintaining and improving access to and/or quality of current system



Source - King's Fund and Health Foundation

70. We note that some studies have estimated the potential additional costs of providing better care. The Health Economics Group at the University of East Anglia, the PSSRU and the Pensions Policy Institute modelled the costs of extending the eligibility criteria to cover those with moderate needs, subject to the means test.¹⁵⁶ They found that this would lead to some 620,000 additional older people receiving care, projected to rise to 700,000 in 2025 and 810,000 in 2030. The net additional cost of this would be an estimated £2.8 billion in 2020, projected to rise to £3.45 billion in 2025 and £4.4 billion in 2030 (at constant 2015 prices).¹⁵⁷ In addition, the King's Fund has estimated that restoring the system to 2009–10 levels, when quality of care and eligibility was wider, would cost an additional £8 billion in 2020–21 and an additional £15 billion in 2030–31.¹⁵⁸ We note that provision of better care could lead to savings elsewhere, most notably through reductions in the numbers of delayed transfers of care and emergency admissions.¹⁵⁹

71. However, it should be noted that neither of these models takes into account the funding of care for working age adults, which currently accounts for around half of local

¹⁵⁶ In general, only people with high levels of care needs (critical or substantial) currently receive publicly funded care.

¹⁵⁷ Written Evidence submitted by the Health Economics Group, University of East Anglia; the Personal Social Services Research Unit, London School of Economics and Political Science; and the Pensions Policy Institute ([FSC0184](#))

¹⁵⁸ The King's Fund and the Health Foundation, [A fork in the Road - next steps for social care funding reform](#), (May 2018)

¹⁵⁹ [Q42](#)

authority spending on social care. As shown below, demographic pressures will mean spending on working age adults will need to increase as well. Although the introduction of reforms such as the cap and free personal care may not have a large impact on funding of social care for working age adults, as most working age adults who need social care have limited assets, reforms to improve the quality of social care, and / or to extend eligibility beyond those with substantial needs, would clearly also increase costs in this category.

72. The following table compiles some recent cost estimates of various reform options produced by different research bodies. However, the assumptions, methodologies and definitions used by each body vary and so the figures are not directly comparable with one another.

Future funding estimates		
PSSRU ¹⁶⁰	At constant 2015 prices and under a set of base case assumptions about trends in demand and unit costs, public expenditure on care for:	
	<ul style="list-style-type: none"> – Older people is projected to rise under the current funding system from around £7.2 billion in 2015 (0.45% GDP) to £18.7 billion (0.73%) in 2035. – Younger adults is projected to rise under the current funding system from around £8.9 billion (0.55%) in 2015 to £21.2 billion (0.83%) in 2035. 	
IFS ¹⁶¹	Maintaining the current system of eligibility and means testing would require spending to increase by a projected 3.9% a year over the next 15 years. An increase from 1.1% of GDP in 2018–19 to 1.5% in 2033–34. (Based on PSSRU analysis)	
OBR ¹⁶²	Spending on adult social care would rise from 1.1% of GDP in 2021–22 to 2.0% of GDP in 2066–67.	
ADASS ¹⁶³	Initial estimates given in oral evidence by ADASS were that the need to spend on social care (older people and working age adults) could double by 2020. Local authorities net spend on social care in 2017–18 was £14.8 billion. ¹⁶⁴	
Estimated extra funding required for social care reforms for older people (The King's Fund and the Health Foundation) ¹⁶⁵		
Policy	2020–21 (£bn)	2030–31 (£bn)
Maintaining current system at 2015–16 levels (no reform)	1.5	6
Restoring to 2009–10 levels	8	15
Cap (£75,000) and floor (£100,000)	5	12
Free personal care	7	14

160 PSSRU ref

161 Institute for Fiscal Studies and The Health Foundation, [Securing the future: funding health and social care to the 2030s](#), (May 2018)

162 OBR, [Extract from the July 2017 Fiscal risks report](#)

163 [Q113](#)

164 Association of Directors of Adult Social Care, [Budget Survey 2017](#), (June 2017)

165 The King's Fund and the Health Foundation, [A fork in the Road - next steps for social care funding reform](#), (May 2018) and [Social care funding options: How much and where from?](#), (May 2018)

'Increases in public spending' required to reform social care (University of East Anglia, the PSSRU and the Pensions Policy Institute)¹⁶⁶		
Policy	2020 (£bn)	2030 (£bn)
Care Act 2014 reforms (April 2015 prices)	Not available	1.8
Extending eligibility to high level needs, subject to means test	2.05	3.0
Extending eligibility to moderate needs, subject to means test	2.8	4.4

Conclusion

73. A significant amount of extra funding is needed to maintain provision of social care at its current level, in the order of many billions of pounds over the next ten to twenty years. However, to ensure good care and a stable and quality workforce, the level of funding required may be much higher.

74. *Costings of future provision of social care need to begin with a clear articulation of what good care looks like and costs for both older adults and working age adults—simply extending the current, inadequate provision of social care to more people is not a tenable long-term position. The Care Act 2014 provides a basis for determining good care. The starting point for the reform process must be to build on this, determining—in conjunction with service users, carers, care providers and care workers—what good care entails.*

75. *In the long term, an independent body should be tasked with modelling the amount of funding needed by social care in the future and ensuring funding keeps pace with need, providing the Government with two yearly forecasts of needs and funding requirements. This is in line with the recommendation made by the House of Lords Committee on the Long-term Sustainability of the NHS for an independent 'Office for Health and Care Sustainability' to advise on all matters relating to the long-term sustainability of health and social care.*

76. Many commentators expressed the view that if we were beginning with a 'clean sheet of paper', it is unlikely that we would design the current system of divisions between health and social care. The difficulties with Continuing Healthcare (CHC) funding—the system through which social care is paid for by the NHS for a small number of people with high health and social care needs—illustrate the problems of setting a hard boundary between health and social care. Only around half of those who apply for CHC funding eventually get it, decision making about eligibility is inconsistent across the country, and the 'cliff edge' between those who qualify and those who do not has been an ongoing source of distress for families, as well as leading to costly and distressing appeals and legal challenges.

77. While some of the evidence we received supported the idea of a social care system free at the point of use, like the NHS, others felt that a balance of responsibility between the state and the individual was appropriate. Our Citizens' Assembly

166 Written evidence from the [University of East Anglia, PSSRU and the Pensions Policy Institute](#)

members expressed strong support for a social care system that was free at the point of use, like the NHS. Clearly, funding a social care system entirely free at the point of use would increase costs substantially and is unlikely to be affordable immediately. However, we support the provision of social care free at the point of delivery as a long-term direction of travel. *In principle, we believe that the personal care element of social care should be delivered free at the point of use to everyone who has the need for it, but that accommodation costs should continue to be paid on a means-tested basis. The aim should be to work to achieve this ideal and to see a gradual transfer of financial responsibility for social care away from the individual at the point of need, making it free at the point of delivery. This should begin by extending free personal care to those deemed to have ‘critical’ needs. However, particularly for younger adults, it is essential that social care is viewed more holistically and funding for ‘preventative’ social care for adults with moderate social care needs is reinstated.*

78. In Germany, social care benefits can be claimed directly as cash benefits, which can support people to be cared for at home, by family carers, for longer. Cash benefits are a much more popular option in Germany than ‘in kind’ benefits, and the focus on family care is underpinned by a framework of support for carers. The German system is discussed in more detail in later in this Chapter. **We recommend that people who receive social care should be allowed to receive direct cash payments to enable them to pay carers, including family carers, to help those families who prefer to care for loved ones themselves at home.**

Options for raising extra funding

Current funding arrangements

79. Social care is currently primarily funded by local authorities through a combination of central government grant, business rates revenue and council tax. In recent years, this has been supplemented by additional ring-fenced sources of funding, including the adult social care precept (discussed at paragraph 18). An increasingly large proportion of local authority budgets is spent on social care, amounting to 37.8% (£14.8 billion) in 2018–19.¹⁶⁷ Sarah Pickup of the LGA said that, given that “quite a lot of council tax and business rates” is currently spent on social care, these revenue streams were likely to continue to be used in this way in the future.¹⁶⁸

80. With regards to council tax, Ms Pickup went on to say the requirement that councils must hold a local referendum in order to increase council tax “has had a really significant impact. Councils have had no levers to raise more money”.¹⁶⁹ We note that the Resolution Foundation has recently considered how council tax reform could increase revenue for public services, stating that currently council tax is “only weakly linked to property values and has failed to capture changes in these over time. This approach is highly regressive”.¹⁷⁰ With modelling they illustrate the potential for council tax reforms to raise additional revenues that could be used to meet health and social care costs.

167 Association of Directors of Adult Social Care, Budget Survey 2018 (June 2018)

168 [Q121](#)

169 [Q120](#)

170 Resolution Foundation, [Home Affairs: Options for reforming property taxation](#), (March 2018)

81. Significant reforms to local government finance—namely increases in the level of business rates retained by local authorities and a review of the local government funding formula—are ongoing. This is an important part of the landscape for the future of social care funding, which is currently funded in part by business rates.

82. In December 2017, the Government announced that it aimed to introduce at least 75% retention of business rates in 2020–21 (currently local government retains 50%) and that, to ensure the reforms are fiscally neutral, certain central government grants to councils would be removed.¹⁷¹ The long-term plan is for local authorities to retain 100% business rates. Closely linked to this, the review of the needs assessment formula (the ‘Fair Funding Review’) will set new baseline funding levels (each local authority’s share of business rate revenue) at the start of 75% retention and each time the system is updated thereafter.¹⁷² Work to ensure that the formula accurately captures current spending needs, and can take into account how they change in the future, is ongoing.

83. The HCLG Committee and its predecessors have repeatedly expressed concerns about the lack of correlation between growth in business rates revenue and growth in spending needs on social care, and the same issue was raised in the evidence submitted to this inquiry. For example, ADASS said that the future funding of social care:

Cannot be seen in isolation from a wider view about local government finance. If future local authority funding is to come increasingly from business rates and council tax, as is planned, these sources will not increase sufficiently to meet higher needs and costs. There is a risk that places with the highest levels of social care need will raise the least through locally raised revenue.¹⁷³

However, the Government’s work on the reforms to local government finance and on the Green Paper do not appear to be linked.¹⁷⁴ Sarah Pickup of the LGA explained why this mattered: “[the additional funding for social care] needs to sit alongside council tax, business rates and, if we retain a means-tested system, the means tested component of that system [...] whatever is designed has to fit in [...] with what is there now”.¹⁷⁵

Future revenue-raising options

84. Much of our evidence suggested the need for national revenue raising options to be considered alongside, or instead of, existing or reformed local government funding arrangements. Given the scale of the funding challenge facing social care, many submissions also argued that a combination of different revenue-raising options will need to be employed. Combining different revenue streams also has the advantage of enabling a more tailored approach, with people contributing to social care in different ways at different points in their lives. The table below sets out some indicative estimates of the revenue that could be generated by some different tax and benefit reforms. Tax revenues and estimates of future funding are highly uncertain.

171 Ministry for Communities and Local Government (MHCLG), [The provisional 2018–19 local government finance settlement](#) (December 2017)

172 MHCLG, [Fair funding review: a review of relative needs and resources: Technical consultation on relative need](#) (December 2017)

173 ADASS ([FSC0116](#))

174 [Q121](#)

175 [Q121](#)

Funding options			
Indicative estimated revenue raised by 1% increase in key tax rates / introduction of new taxes, 2020–21 and 2030–31 [Source—The King’s Fund and the Health Foundation, May 2018]¹⁷⁶			
Tax type	Detail	2020–21 (£bn)	2030–31 (£bn)
Income tax	Basic	3.8	5.1
	Higher	1.3	1.8
	Top rate	0.4	0.9
	No uprating of tax thresholds (fiscal drag)	6.8	n/a
NI contributions	Extend 65+	1.0	1.0
	Main rate	3.5	4.4
	Higher rate	1.0	1.6
	Employers contribution	4.6	6.0
VAT	Main rate	5.0	5.2
Council tax	1% uniform increase	0.5	Not available
Winter fuel payments	Abolish	2.1	Not available
	Means test	1.8	Not available
	Tax as income	0.1	Not available
Pensions	Double lock maximum	0	7.2
Wealth taxes	13% ‘Care duty’	4.8	Not available
	Inheritance tax (10% increase)	1.5	Not available
Direct effects of illustrative changes, 2020–21 and 2021–22 [Source—HMRC, April 2018]¹⁷⁷			
Tax type	Change	2020–21	2021–22
NI contributions	Self-employed (1% rise in both rates)	0.6	0.56
Corporation tax	Increase by 1%	2.6	2.8
Inheritance tax	Inheritance tax (1% increase)	0.13	0.145
Duties	Beer and cider duties	0.025	0.025
	Wine	0.045	0.045
	Spirits	0.025	0.025
	Tobacco	0.005	0.005
Council tax reform options, 2015–16 [Source—Resolution Foundation, March 2018]¹⁷⁸			
New top band ¹⁷⁹		0.1	Not available
Mansion tax ¹⁸⁰		1.1	Not available
A new property tax ¹⁸¹		8.6	Not available

176 A 1% tax rate with a £100,000 tax-free allowance per property.

177 The Health Foundation and the King’s Fund, [Social care funding options: How much and where from?](#), (May 2018)

178 HMRC, [Direct effects of illustrative tax changes](#), (April 2018)

179 Resolution Foundation, [Home Affairs: Options for reforming property taxation](#), (March 2018)

180 A new band in England containing the highest value half of properties in band H (£320,001 plus), with a council tax increase for these properties of 17%.

181 1% on the value of properties above £2 million and 2 per cent on the value of properties above £3 million.

Funding social care in other countries—‘social insurance systems’

85. Much of the evidence we have heard has drawn on ‘social insurance systems’ in other countries as examples that England might learn from. Germany and Japan are frequently cited examples. While it is clearly not possible or desirable to import a funding model ‘wholesale’ from another country—bearing in mind differences in culture, administrative mechanisms, other funding mechanisms, and desired policy outcomes—it is nevertheless possible to draw upon certain elements. The Japanese and German systems (details of which are given in the boxes below) have similarities in their fund-raising mechanisms, whereby an earmarked contribution is collected from earnings, earmarked specifically for social care, and benefits (in terms of access to social care) are introduced immediately. Both systems also have elements which weight contribution levels according to age. In Germany, older, retired people pay extra contributions which effectively cover the employer share that reduces the cost for employed adults; in Japan contributions begin from age 40. It should also be noted that in both of these systems, individuals may still pay a substantial contribution towards the cost of their social care.

The German social care system [source—Professor Caroline Glendinning and Matthew Wills]¹⁸²

The German long-term care insurance scheme (LTCI) was introduced in 1994. The fact that the scheme is universal, and that all ages contribute, have been identified as factors in the its popularity and acceptability. Its perceived advantages include:

- Maximum risk pooling through single, earmarked funding stream
- Universal coverage—reduced exposure to catastrophic costs for people of all ages (although the scheme does not cover all care costs).
- Equitable—similar benefits for similar levels of care need.
- Sustainable—key to building and maintaining public support.
- Encourages investment—predictable funding encourages market entry, investment in physical and human capital and quality improvement.
- Encourages and supports home and family-based care; only 25% of beneficiaries use formal services.

The scheme is administered by individual local ‘funds’ which are accountable to federal government.

All people in employment pay in 2.55% of their income—the cost is split between employers and individuals when an individual is working, but after retirement the individual pays all, to cover the employer portion. Self-employed people also have to pay the full premium themselves. Childless people pay a slightly higher rate of 2.8%.

There is no means test, but the amount an individual receives does vary according to assessment of need. Benefits can be a cash benefit—which can be given to family carers; an ‘in kind’ benefit to be spent on home care or other types of care (like a voucher); or residential care benefits. Cash benefits are paid at a lower level than the

182 Emerita Professor Caroline Glendinning ([FSC0091](#)); Professor Caroline Glendinning and Mathew Wills ([FSC0194](#))

‘in kind’ benefit, but are much more popular. The amount an individual receives varies from £109 per month (low level needs, cash payment) to £1,763 (high level needs, residential care). There is a substantial level of private contribution to social care costs in Germany. In May 2017 the average monthly care-related co-payment was €587/£512 (the specific amount varies between care homes, but not between people with different levels of care need). The average monthly user payment for hotel costs was €681/£594 and €413/£360 for maintenance/infrastructure (December 2015 figures—these are indicative only.)

LTCI currently covers around 58% of the average costs of residential or formal domiciliary service provision (up from round 50% since the increase in benefit levels in January 2017). The shortfall is made up by user co-payments or, for those with very low incomes, means-tested social assistance. However, the significant LTCI contribution (based on level of care needs) towards the costs of formal domiciliary or residential care services means that users ‘spend down’ their savings much more slowly and will therefore be less likely to need to seek means-tested social assistance.

Dementia, cognitive impairments, and mental health conditions did not used to be covered by the scheme but it has recently been extended to cover them.

The Japanese social care system [Source—the Nuffield Trust]¹⁸³

The Japanese social insurance system was introduced in 2000. The long-term care insurance (LTCI) system is administered at municipality level and funded through a combination of social insurance contributions, general taxation and user contributions (known as co-payments). Every member of the population must pay into the system from the age of 40.

People who pay premiums are split into two groups: those known as the ‘primary insured’ are over the age of 65 and their contributions are withheld from their pension payments and collected at municipality level. The ‘secondary insured’ are those between 40 and 64 years of age. For those in employment, individuals’ contributions are shared with employers. These premiums are determined and collected nationally and redistributed to municipalities. When redistributing, the municipality’s ratio of the 65–74 and 75+ age groups to the working-age population is taken into consideration to ensure that allocations reflect need.

50% of funding for social care comes from taxation—12.5% from municipality taxation; 12.5% from prefectures taxation; and 25% from state taxation. The other 50% comes from social insurance premiums—22% from the 65+ age group, 28% from the 40–64 age group. In addition to paying premiums, service users must pay a co-payment (financial contribution) when accessing services, although those on very low incomes are exempt. When the service was first introduced, this was 10% of the total cost of care, rising to up to 30% for some in more recent years. Co-payments are paid up to a ceiling.

If individuals want to access care beyond their entitlement, they must pay 100% of their costs out of pocket (Rhee and others, 2015). In reality, because provision

183 The Nuffield Trust, [What can England learn from the long-term care system in Japan?](#) (May 2018)

is relatively generous, only a very small proportion of service users self-fund at all. It is estimated that eligible people take up only around half of the service amount they are entitled to because of concerns over the co-payment (Campbell and others, 2016). Since 2005, people using services have been required to pay ‘hotel costs’ (for residential care) and a contribution to meals. These contributions are means tested and capped for people on low incomes (Rhee and others, 2015).

A standardised assessment procedure is used by municipalities to group people into one of seven eligibility levels. The assigned level of need determines the monthly notional budget individuals have available to them and the services they can access. Income levels and the amount of informal care/family support available are not taken into consideration when making these needs-based assessments. Importantly, there are no cash benefits. This was decided in order to help shift the burden of caring from families—in contrast to other countries such as Germany. A care manager, in partnership with the individual, is responsible for designing, monitoring and overseeing care plans.

The introduction of LTCI has resulted in a very active competitive market, comprising thousands of mostly small providers which are a mix of for-profit and not-for-profit companies, social enterprises and charities. Within five years of its inception, the number of home care providers had more than doubled (Ministry of Health, Labour and Welfare, 2011). In order to entice new providers in to the market, they were allowed to make profit (something that had not been allowed under the previous system). However, new providers were not allowed to provide institutional care as the government wanted to incentivise community and home-based provision (Ikegami, 2007)

Citizens’ Assembly views

86. Our Citizens’ Assembly Members considered a range of options for raising additional money for adult social care through public funding:

The top option on first preferences was the social insurance model—a separate, publicly organised, compulsory payment (calculated as a percentage of income) paid by everyone from age 40 onwards. Some Assembly Members favoured the social insurance option as it would “give longer for younger people until they have to pay”, but there was concern that people “can still be struggling at 40” and that it would create “additional costs on people still with high costs (e.g. families and mortgages)”. The options involving income tax, on the other hand, were favoured because they were progressive and “based on ability to pay”.

When lower preferences were counted, four options commanded good levels of support: an earmarked increase to income tax, an increase to income tax, a social insurance scheme, and extension of National Insurance to those who work beyond state pension age (C). While members recognised that the extension of National Insurance would not generate a significant amount of funds towards adult social care (and therefore was not a solution on its

own), they tended to feel that, alongside other changes, it sent an important message that older people were not exempt from paying for their generation's social care if they were still earning.

Options related to VAT, council tax and inheritance tax, on the other hand, received very low levels of support. Both VAT and council tax were rejected due to perceptions of unfairness as they would "hurt people on low income" or "leave us with a postcode lottery". The inheritance tax options were disliked because there would be "not enough gain to make it worthwhile", the "very wealthy will get around it" and because it is "already so high".

During the course of the discussion, Assembly Members suggested a number of other public funding options that could contribute to funding social care, including a "wealth tax", "sugar / junk food tax", "clamping down on tax avoidance", and revisiting "overall priorities on where general taxation is spent". Assembly Members were also interested in ways that companies could contribute through tax, including through higher National Insurance contributions or a compulsory social responsibility tax.

87. Extending National Insurance was also suggested in many of the written evidence submissions received from individuals, along with increases in general taxation, and council tax rises, especially in higher tax brackets. The Assembly members were also strongly in favour of earmarked taxation: They explained that this was because:

a) the public would "know where the money is going" and, therefore, b) that it would be more "appealing", "sellable" and "palatable" to voters. The lack of public awareness of social care came up throughout the discussions. Assembly Members considered that having, themselves, become much better informed about funding issues, they would now be prepared to pay more.

The Assembly members did however identify some risks associated with earmarked taxation:

[Their] concerns with earmarked taxation related to it being "too prescriptive", "less flexible" and that it "doesn't accommodate changing needs over time". Assembly Members also recognised that it "may not raise enough funds and need topping up".

Some Assembly Members were also concerned that it "goes against the principle that we don't choose what we pay for" through taxation, while others were concerned about public awareness and whether government could be trusted to use the money as intended—"There will be a scandal of misuse!"

Conclusions and recommendations

88. **There is a clear need for increased funding for social care. Given the scale of the additional funding likely to be needed, a combination of different revenue-raising options will need to be employed, at both a local but also a national level. Combining different revenue streams also has the advantage of enabling a more tailored approach, with people contributing to social care in different ways at different points in their lives.**

At local level:

89. *There should be a continuation for the foreseeable future of the existing local government revenue streams. In 2020, these funding streams should be enhanced through 75% business rate retention. This should be used to fund social care rather than the replacement of grants the Government is proposing to introduce. While business rates revenue is poorly matched with social care funding needs, it is a source of funding expected to come to councils in 2020. We welcome the fact that the Government is currently working to review and update the formula which determines how revenue is redistributed according to need.*

90. *In the medium term, there should be a reform of the council tax valuations and bands to bring them up-to-date.*

91. *In the future, as other funding streams develop, the contribution from council tax and business rates to social care funding could reduce, allowing councils to better fund other important services.*

At a national level:

92. *Local government funding will only ever be one part of the solution for social care, and it is clear that extra revenue will also need to be raised nationally.*

93. *We heard strong support for the principle of earmarking tax—it was felt that establishing a visible fund for people to contribute to that is clearly, transparently and accountably linked to spending on social care is key to gaining public acceptance for this measure. The proposals for a long-term care insurance scheme in Germany won support from the public there for similar reasons.*

94. *We therefore recommend that an earmarked contribution, described as a ‘Social Care Premium’, should be introduced, to which individuals and employers should contribute. This can either be as an addition to National Insurance, or through a separate mechanism similar to the German model. The Social Care Premium could be managed by central government, and audited by the National Audit Office, or managed separately by a statutory body or not for profit insurance based funds, as is the case in Germany.*

- *To ensure the accountability desired by the public, we believe that the funding derived from the Social Care Premium should be placed in an appropriately named and dedicated fund. The fund should be regularly audited and required to publish its spending and accounts. We suggest that the National Audit Office could perform this function and report its findings annually to Parliament. We were attracted by the visibility afforded by the German social care insurance system, and it is with this in mind that we make this recommendation. We believe that the fund we are proposing would demonstrate to the public that the Government has accepted that the need for social care is a risk requiring protection.*
- *Following our principle of fairness between generations, we recommend that those aged under 40 should be exempt from the Social Care Premium, and that it should also be paid by those over the age of 65.*

- *Specific consideration should be given to setting a minimum earnings threshold for the Social Care Premium—to protect those on the lowest incomes—and to lifting the maximum threshold for such payments (currently set at £46,350 per year). Consideration should also be given to including unearned income, for example pensions and investments, in contribution calculations. The way in which self-employed people pay National Insurance should also be reformed to ensure they pay equivalent contributions.*
- **As a further development, the principle of having an earmarked fund that the public could see is for social care could be extended to funding of the NHS, providing a consistency and coherence to the link between social care and the NHS, underpinned by closer working and integration at a local level. In the long term, we believe there is a strong case for reimagining this as ‘National Health and Care Insurance’.**
- **There would also need to be consideration of the means for assessment of need and a mechanism for increasing the required premiums to meet changes in demand over time. Wherever possible, these mechanisms should be independent statutory bodies to remove the short-term political cycles and decision-making from the process. This task could be undertaken by the independent body to which we refer in Paragraph 75 above.**

95. In addition, in order to remove the catastrophic cost of social care for some people, and to spread the burden more fairly, we also recommend that a specified additional amount of Inheritance Tax should be levied on all estates above a certain threshold and capped at a percentage of the total value, and the monies raised used to support the relevant funds as described above, until the level of the Social Care Premium meets demand unaided.

4 Social care and its wider context— health, public health and housing

96. Adult social care is part of a complex system of related public services and forms of support, which include health, housing, welfare and benefits and even leisure and wellbeing; ideally, these services should be working together to meet adults' needs. An analysis of the challenges facing social care would be incomplete without considering this wider context and, in the following paragraphs, we consider the interdependencies between social care and health care, public health and housing.

Interdependencies between health and social care

97. Health and social care are highly interdependent; for example, inadequate social care can lead to a deterioration in a person's health and ultimately admission to hospital, and people who are ready to leave hospital may be unable to do so if there is no home care in place for them. In December 2017, there were 145,300 total delayed days, equivalent to 4,688 daily beds occupied by a patient who was delayed in transferring, up from 4,485 in December 2014. Over a third of those delays were due to an inability to access social care packages.¹⁸⁴ The National Audit Office has found that one fifth of emergency admissions to hospital were for existing conditions that primary care, community or social care could manage.¹⁸⁵ NHS Providers described the impact on the NHS:

Such delays and avoidable admissions have a substantial impact on trusts, both financial and in time spent. The NAO estimates that the gross annual cost to the NHS of keeping older patients in hospital who no longer need to receive acute clinical care is around £820m. DTOCs can disrupt patient flow through the NHS with, for example, patients arriving at A&E then waiting longer for treatment or admission because there are fewer beds available elsewhere in the hospital.¹⁸⁶

Equally importantly, avoidable hospital admissions and delays in leaving hospital can also have a serious effect on a person's functional ability, making it difficult for them to return to independent living. Older people can lose significant muscle power in a little as half a day in hospital.¹⁸⁷

98. Simon Bottery of the King's Fund described the impact of poor integration on a person's experience of care, giving examples of "arguments about whether a district nurse needs to apply E45 cream or whether that can be done by a care worker", and of three or four people visiting someone at different times of day to carry out different tasks.¹⁸⁸ Organisations representing both older and working age adults told us that, although integrating services meant different things for different age groups, ultimately care needed to be integrated around the individual receiving care. This is particularly the case for people with dementia; the Alzheimer's Society said:

184 NHS Providers ([FSC0147](#))

185 National Audit Office, [Adult social care in England - an overview](#) (2014)

186 NHS Providers ([FSC0147](#))

187 NHS Providers ([FSC0147](#))

188 [Q57](#)

The web of care that they access often carries across from health to social care without people necessarily wanting to know the difference or knowing that they are going from one to the other. People will often want good care, understanding, and a friendly face, and a knowledgeable face, regardless of where they see that [...] someone with dementia might come across 50 different professions as part of the support that they might need.¹⁸⁹

Age UK echoed the need for an approach to care giving which is joined up around individuals, and highlighted the crucial role of community health services, describing them as “very unsung heroes, [...] such as district nurses, coming in and tending to things like pressure sores and ulcers, which [...] if not treated properly, can end up precipitating someone into hospital”.¹⁹⁰

99. Scope outlined the reasons why, for working age adults with disabilities, integration needs to be broader:

Some of the touch points are different. It is not about keeping people out of hospital necessarily; it might well be about preventing isolation, which might then have a knock-on impact on mental health care, for example [...] from a Scope point of view, we are also interested in integration that looks a bit beyond the health system [it] should be with the employment system and the housing system, and those things need also to be looked at because disabled people need holistic support to be independent.¹⁹¹

100. Health and social care are highly interdependent. The debate in this area is often focused on delayed transfers of care—where people who are fit to leave hospital are unable to because social care is not available—and the increased costs associated with this. Reducing delayed transfers of care and emergency admissions through better provision of social care can generate savings by reducing the inappropriate use of hospital services. However, we are equally concerned about the impact that emergency admissions and delayed transfers of care can have on people’s lives—for both working age adults and older people unnecessary time spent in hospital can result in loss of confidence to return to independent living. From the point of view of a person with health and social care needs, improved integration between health and social care services has the potential to improve outcomes, and *we recommend that local attempts to better integrate services continue apace*.

Delivery and integration at a local level

101. In contrast to the NHS, social care is currently provided at a local level—local authorities commission care most care from the private and voluntary sectors. Our witnesses agreed that social care should be provided locally: “Care that is going to be sensible in the highlands and islands is going to be rather different from [that which is] sensible in Camden”.¹⁹² They also felt that integrating services around individuals is better done locally:

189 [Q22](#)

190 [Q22](#)

191 [Q21](#)

192 [Q58](#) [Andrew Dilnot]

That happens in a place, so we need place-based, person-centred and population-focused services, not something that is driven from a building in London or even from buildings in regions. I think you bring those services better together in local places and you get closer to what the citizens need and want [...] in fact, in the NHS there needs to be more delegated decision making at a local level, because, often, what happens is that good local partnership is undone by a top-down approach.¹⁹³

102. The Health and Social Care Committee has recently published a report on Integrated Care in which it describes the latest progress on improving integration as follows:

The 44 Sustainability and Transformation partnerships (STPs) are now at different stages in their journey towards further integration as integrated care systems (ICSs). Systemic funding and workforce pressures affect almost every area. Some areas have made considerable progress in light of these pressures, but those furthest behind are struggling with rising day-to-day pressures let alone transforming care. ICSs are more autonomous systems in which local bodies take collective responsibility for the health and social care of their populations within a defined budget. A cohort of 10 ICSs, made up of the leading STPs, is currently paving the way for other systems. While these areas have made good progress in difficult circumstances, they are still nascent and fragile.¹⁹⁴

103. Our evidence was supportive of the place-based approach to care being promoted through the STP process. However, a note of caution was sounded about ensuring that councils are fully engaged in the process, and that financial challenges can divert the focus from integrating primary, community and social care services:

[The STP process] is really good in some places, it is okay in others, but a lot of council chief executives and leaders are still telling us that they are insufficiently engaged; and there is a tendency to revert to dealing with the here and present issue, which might be financial deficits or potential projected deficits, particularly in trusts. For all the plans and talk about primary community, and the need for all those services to be in place, there is much less focus on that than on restructuring and financial challenges.¹⁹⁵

Witnesses also emphasised the important role in integration that could be played by Health and Wellbeing Boards.¹⁹⁶

104. There is a strong case for the local delivery of social care at a local level—this brings the important benefits of links with housing and other local services, as well as local accountability. *Better integration of health and social services is key, and the potential of Health and Wellbeing Boards, as well as new arrangements including integrated care systems, organisations and partnerships, should be used to the maximum to support integration.*

193 [Q133](#)

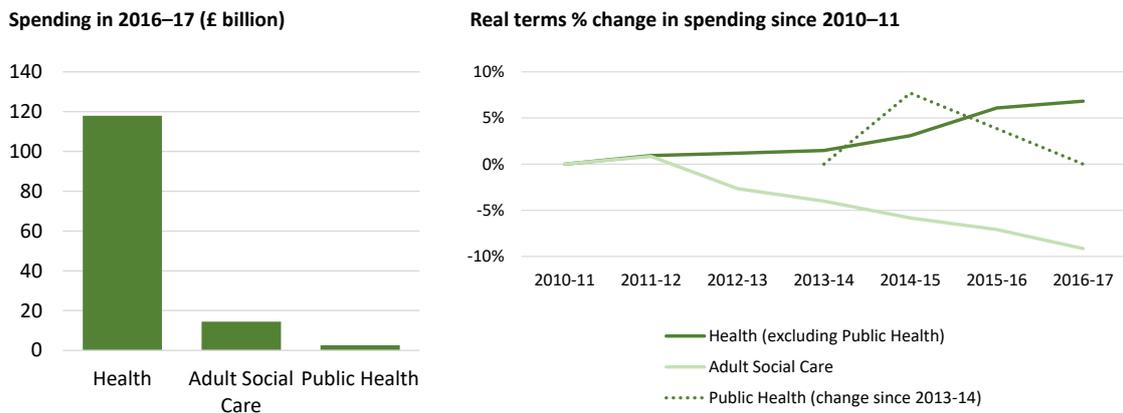
194 Health and Social Care Committee, [Integrated care: organisations, partnerships and systems](#), Seventh Report of Session 2017–2019 (June 2018)

195 [Q137](#)

196 [Q136](#)

Social care, health and public health funding

105. While there is significant support for integration, we heard that it would not generate the levels of savings required to reduce the need for additional funding for social care.¹⁹⁷ Simon Stevens, Chief Executive of NHS England, repeated in evidence to our inquiry his argument that “putting two leaky funding buckets together does not make a watertight health and care service”.¹⁹⁸ However, it is clear that the funding of social care, health, and also public health are interrelated, and that spending growth or restraint in one area has an impact on the others. The NHS Five Year Forward View, published in 2014 by NHS England, set out an ambitious forward programme for the NHS but cautioned that social care and public health services would also play a role in its delivery. With regards to the plans recently announced by the Prime Minister for a ten-year NHS funding settlement, Simon Stevens argued that an essential part of this would be addressing the availability of social care.¹⁹⁹ Public health means a focus on preventing ill health from developing—for example, vaccination schemes, and healthy living support to prevent the development of heart disease and diabetes. In 2013, responsibility for public health passed from the NHS to local authorities. Despite the important interdependencies between social care, health care and public health, spending on social care and public health has fallen in recent years, compared to growth in health spending. In addition, spending on prevention in social care has fallen in recent years.



Source— Library Briefing Paper, [Adult Social Care Funding \(England\)](#), 19 April 2018; HofC Library Briefing Paper, [NHS Funding and Expenditure](#), 13 April 2018; The King’s Fund, [Spending on public health](#), 18 May 2017. Adult Social Care and Health expenditure figures have been converted into real terms using HM Treasury, [GDP deflators](#), March 2018. Note: The public health spending changes have been calculated from a like-for-like series from the King’s Fund - these figures are rounded to the nearest £0.1bn.

106. There was significant support from our Citizens’ Assembly for considering the funding of health and social care together; however, Assembly Members were concerned “not to allow social care to become the underfunded orphan service”. This echoed the views of some of our witnesses who warned of the risk of “medicalising the care system” and the need to ensure that the “values, principles and professional ethos of the different groups” working in health and social care are protected.²⁰⁰

197 The King’s Fund ([FSC0174](#)); National Audit Office, [Health and social care integration](#), (February 2017)

198 [Q170](#)

199 [Q156](#)

200 [Q23](#); [Q57](#)

107. There is no evidence as yet that integration of health and social care at a local level delivers cost savings, and integration of health and social care services will not generate funding to address the social care shortfall. Indeed, integration may result in short term increases in costs due to previously unmet need. However, better integration can deliver better services for individuals, by placing them at the heart of care. ***Given the interdependencies between the provision of health care, social care, and also public health, we recommend that in its discussions of future funding settlements the Government should consider all these in the round.***

Housing

108. As referred to above, delivery of social care at a local level enables links to be made with housing services. This is particularly important as housing is a key determinant of health and wellbeing for people of all ages and consequently their likelihood of needing health and social care services. Well-maintained, appropriately adapted and safe housing plays a key role in keeping people healthy and enabling them to live independently. In addition, specialist housing, particularly extra care housing where care is delivered on-site, can have health and wellbeing benefits and lead to cost savings.²⁰¹ This is also the case for high quality, supported housing for people with learning disabilities.²⁰²

109. Poor quality, unsafe and poorly-adapted housing can have the opposite effect on health and wellbeing, and it can also lead to unplanned admissions to hospital and delayed discharges. Given that 78% of older people are owner occupiers, who may have low incomes and be struggling to keep up with maintenance, repairs and heating, they are particularly vulnerable. In addition, the quality of the home environment is a key factor in ensuring that home care, the type of care most commonly provided, is delivered effectively.²⁰³ John Jackson of ADASS explained the challenge presented by housing and why it needed to be tackled:

The reality is that we have a lot of older people living in their family homes and very much enjoying it, but there is a real question that, at some point in time, they are going to become harder to manage and there is more likelihood of things going wrong because of stairs and so forth [...] having a housing strategy, which is thinking about what older people want, and not a question of forcing or nannying people, or anything like that, but giving some choices to older people as they age, is [...] positive for social care.²⁰⁴

110. Despite a clear need for integration, we heard that there was “variable progress” being made on integration between health, social care and housing services,²⁰⁵ and we note that, although most STPs mention housing, this often does not translate into their planning and analysis.²⁰⁶ This reinforces the findings of the HCLG Committee’s inquiry on housing for older people. The Committee recommended that housing services should take equal status to health and social care services in the planning and implementation of integration, and that the Green Paper must actively consider the importance of housing

201 [Q139](#)

202 [Q139](#)

203 It is estimated that 650,000 people receive care at home and 421,000 receive care in residential settings. Source: LaingBuisson, Homecare, Supported Living and Allied Services, UK Market Report.

204 [Q139](#)

205 [Q139](#)

206 The King’s Fund ([FSC0174](#))

for older people.²⁰⁷ Its predecessors also found that lack of joined up working between district and county councils on Disabled Facilities Grants is often the cause of delays to the delivery of home adaptations.²⁰⁸

111. The Green Paper must give due prominence and consideration to the role of housing as a key determinant of health and wellbeing and consequently need for health and social care support. In particular, it should consider how, through improvements, adaptations and wider access to specialist housing, we can ensure that the home environment better aids health and wellbeing and the delivery of social care, and how to facilitate this through better integration of social care, health and housing services.

207 HCLG Committee, [Housing for older people](#), Second Report of Session 2017–19 (2018)

208 HCLG Committee, [Adult social care](#), Ninth Report of Session 2016–17, HC 1103 (March 2017)

5 Political and public consensus on social care

A cross-party approach: a parliamentary commission

112. Aware that previous attempts to reform social care had not come to fruition, we wanted to explore what was needed to ensure that the forthcoming Green Paper would lead to successful reform. We consider what might be required in this chapter.

A cross party approach

113. We received strong representations from the sector that, after successive failed attempts over many years, reform was now critical²⁰⁹ and that it would stand most chance of success if the proposals were developed and supported by all political parties.²¹⁰

114. Within Parliament, there is also a clear appetite for a cross-party approach to reform. In November 2017, 90 Members wrote to the Prime Minister arguing that “only a cross-party approach could deliver a sustainable settlement for [social care] where conventional politics had failed to do so”.²¹¹ This followed a letter to the Prime Minister from the Chairs of the Public Accounts, Health and Social Care and Housing, Communities and Local Government Committees in January 2017, calling for a “political consensus” on funding social care.²¹²

115. A cross party approach is likely to be particularly valuable in identifying and gathering support for the sources of extra funding for social care. Sir Andrew Dilnot pointed out that the fact that a cap on care costs was already on the statute book, albeit not implemented, showed there was political consensus on “what the money should be spent on”.²¹³ He continued:

Where there is not consensus is where the money should come from. That is what is always politically most toxic for Governments. The debate is much more now about where the money should come from than about what the money should be spent on. My advice for any institution trying to build consensus would be try to focus on that.²¹⁴

116. Indeed, previous attempts to identify sources of additional revenue for social care have become highly politicised. In 2010, plans by the then Labour Government to introduce a National Care Service paid for by a 10% levy on top of inheritance tax, were labelled a “death tax”. Then, in 2017, proposals in the Conservative manifesto to means test the Winter Fuel Allowance and scrap the triple lock on pensions in order to pay for the introduction of a more generous means test with a floor of £100,000 of savings and assets (including housing assets) attracted criticism from other political parties and in the

209 [Q25](#)

210 [The King’s Fund \(FSC0174\)](#); [The Local Government Association \(FSC0049\)](#); [ADASS \(FSC0116\)](#); [County Councils Network \(FSC0118\)](#)

211 [Social care: MPs seek cross-party group to ‘sustain’ NHS, BBC News \(18 November 2017\)](#)

212 [Letter to Prime Minister from the Chairs of the then Communities and Local Government Committee, the then Health Committee and the Public Accounts Committee \(6 January 2017\)](#)

213 [Q60](#). See also [ADASS \(FSC0116\)](#)

214 [Q60](#)

media. And, before it was subsequently announced that there would be an absolute limit on the amount people would have to pay towards their care, the floor itself was labelled a “dementia tax”.

117. A cross-party approach is also more likely to ensure lasting reform, insulated from future political interference. This is particularly important in the case of complex, multiple-stranded reform likely to take longer than a single Parliament to implement.²¹⁵ The members of the Citizens’ Assembly viewed future political interference as a particular risk. Their foremost principle underpinning reform was that the solution should be “long term”, “untouchable” and have “constitutional protection”. They identified one of their key messages as “Make sure there is cross-party consensus and social care stops being pushed about by party politics”.

118. Lastly, Germany’s experience of reforming social care funding through political consensus is instructive. In 1994, in response to increasing pressures on their publicly funded care system, they introduced a mandatory long-term care insurance scheme requiring contributions from employees and employers. As the then CLG Committee discovered on its visit to Berlin in December 2016, attracting cross-party political backing for the proposal was essential to its eventual implementation. This finding led to their recommendation in their March 2017 report on social care that political parties across the spectrum should be involved in the process of reaching a solution in England.²¹⁶

119. A cross-party approach on reforming social care funding is essential if we are to achieve final and lasting reform. There has been a failure in the past to make progress on reform, resulting from the use of unhelpful, party political terms like ‘death tax’ and ‘dementia tax’ which could have been curbed by a cross-party approach. This issue is unlikely ever to be fairly addressed in the midst of an election campaign. Furthermore, such an approach would also help to guard against partisan political interference after the reforms have been implemented.

A parliamentary commission

120. As the discussion in previous chapters has demonstrated, long-term funding reform for social care is a challenging issue, particularly given that aspects of reform relating to revenue raising can become highly contentious. While a cross-party approach would help to alleviate this, the vehicle or mechanism through which it can be delivered is also extremely important.

121. The Institute for Government (IfG) identified the mechanisms that have previously been used to tackle “similarly knotty issues”, pointing to the Pensions Commission, the Parliamentary Commission on Banking Standards (PCBS) and the Committee on Climate Change.²¹⁷ They said that inquiries or commissions could be “effective mechanisms for building and maintaining political consensus on controversial issues”. By way of illustration, the PCBS was created by Parliament, at the instigation of the Government, to examine professional standards and culture in the banking sector following the LIBOR

215 ADASS ([FSC0116](#)), The King’s Fund ([FSC0174](#))

216 HCLG Committee, [Adult social care](#), Ninth Report of Session 2016–17, HC 1103 (March 2017)

217 Institute for Government ([FSC0163](#))

scandal and conduct pre-legislative scrutiny of the Financial Services (Banking Reform) Bill. The PCBS is widely considered to have been a success, setting out proposals for radical reform of the industry.

122. The concept of parliamentary commission commanded support among the social care sector,²¹⁸ unlike a Royal Commission²¹⁹ which it was felt would take too long given the urgency of the need for reform²²⁰ and would repeat the research and analysis already undertaken by previous commissions.²²¹ UNISON, however, was not convinced that a cross-party commission would work, saying that “narrow party interests [were] always likely to intrude on genuine attempts to foster cross-party consensus”.²²²

123. A parliamentary commission is also the approach favoured by many parliamentarians and there would be a clear benefit to harnessing this momentum. In March 2018, over 100 MPs from across the political spectrum, including 21 select committee chairs, wrote to the Prime Minister urging her to set up a Parliamentary Commission on Health and Social Care.²²³ They pointed to the success of the PCBS and emphasised that such commission could build support for reforms in parliament, report in a timely fashion and take a “whole system” approach, considering funding for social care, health and public health in the round.

124. The IfG has identified the conditions which are helpful to the success of a commission. Nick Davies, Programme Director at the IfG, told us that, for the best chance of success, it should be commissioned by the Government and have “active buy in” from either the Prime Minister or the Chancellor, ideally both, and “reach out” and “bind in” the Opposition.²²⁴ In addition, it would need to be timely (reporting within nine months to a year), be properly resourced and be led by someone respected on both sides of the House and with a grasp of both the policy and politics involved. Lastly, and critically, it would need to engage successfully with the public (we consider the need for public engagement in the next section).

125. Although not cross-party, the 2002–6 Pensions Commission was cited in evidence as another successful example of a commission building consensus around a charged political issue to achieve effective outcomes.²²⁵ It is particularly noteworthy for its independence from the Government, effective chairing, rigorous approach and analysis, and in-depth and skilful engagement with major sector stakeholders and the public.²²⁶

126. The concept of a cross-party parliamentary commission currently has the support of more than 100 MPs from all English political parties. As a proven mechanism for building and maintaining political consensus on difficult issues, and following other unsuccessful attempts at reform, we strongly recommend that a parliamentary

218 The King’s Fund ([FSC0174](#))

219 A royal commission is an ad hoc advisory committee appointed by the government (in the name of the Crown) for a specific investigatory and/or advisory purpose. They usually take several years to report.

220 UNISON ([FSC0096](#)), ADASS ([FSC0116](#))

221 The King’s Fund ([FSC0174](#))

222 UNISON ([FSC0096](#))

223 [Letter to the Prime Minister from the Chair of the Liaison Committee signed by 100 MPs](#), March 2018

224 [Q60](#)

225 [Q80](#)

226 Institute for Government, [Pensions reform: The Pensions Commission \(2002-6\)](#)

commission offers the best way to make desperately needed progress on this issue. We note the key elements of the Pensions Commission which led to its success—independence, timeliness, engagement with key stakeholders and the public, and transparency.

127. Using the principles set out in this report as a basis for proceeding, a parliamentary commission should look at the specific proposals we are making, together with the recommendations made in the Green Paper, in order to determine the mechanisms which will provide a long-term funding solution for social care. To ensure the systems are properly joined up and a ‘whole systems’ approach to funding reform is taken into account, the parliamentary commission should also look at how the funding for social care relates to funding for health and public health.

Public engagement

128. Alongside political consensus, public engagement in the reform process—with the general public, as well as people who receive social care and other stakeholders—will be critical to its success.²²⁷ Crucially, engaging service users and other interested parties will improve the quality of the proposals²²⁸ and ensure that they meet people’s needs and are workable.²²⁹ We commissioned a Citizens’ Assembly for precisely these reasons, keen to ensure that our inquiry and its eventual conclusions and recommendations were informed by the views of the public.²³⁰

129. Building understanding of social care is an essential element of successful public engagement. As identified earlier, not only is the public reluctant to consider social care, they have a poor understanding of the current system, the challenges it faces and how it is paid for.²³¹ Indeed, many people anticipate that their social care will be free, believing they will have paid for it via taxation throughout their lives.²³² This lack of knowledge can be a barrier to securing the public’s support for proposals which stand to affect them financially. Caroline Abrahams of Age UK explained:

Politically, having to say to people, “Well, you know that thing you thought was free, here is the bad news: you are going to have to pay something towards it. But here is the good news: it is not quite as much as you might otherwise would,” is a tremendously hard argument to get across.²³³

The failure to build public understanding ahead of attempts at reform in 2010 and 2017 may have contributed to the poor reception which they received.²³⁴ Indeed, the Alzheimer’s Society said that the dementia tax debate revealed that the public had “little understanding of how the system works”. We heard that provision by the Government of accessible, easily understandable and clear information alongside the reform process would help.²³⁵

227 Institute for Government ([FSC0163](#))

228 Institute for Government ([FSC0163](#))

229 Leonard Cheshire Disability ([FSC0101](#))

230 The 47 Assembly members were representative of the English population and a proportion had experience of the social care system, either directly or through a relative or friend.

231 [Q50](#)

232 [Q19](#), [Q28](#)

233 [Q28](#)

234 The King’s Fund ([FSC0174](#))

235 Care and Support Alliance ([FSC0180](#)). See also Demos ([FSC0148](#))

130. The evidence we received did not generally consider how to engage the public on social care reform; indeed, the IfG said that the particular methods used would depend on the role of the body conducting it.²³⁶ However, organisations submitting evidence had often conducted their own public engagement—using online surveys, focus groups, workshops and interviews—showing that there are a range of possible approaches and methods. Our Citizens’ Assembly also provides a possible model for further public engagement, combining building understanding with an exploration of the issues and decision-making. Assembly members were taken through a process of learning, deliberating and decision-making which enabled them to tackle difficult questions about where funding for social care should come from. They identified the benefits of this process themselves, agreeing on the message:

Don’t underestimate the public—once they know they will be willing to pay. The lesson from these two weekends is that when everyone is informed consensus develops.

Elsewhere we heard that, once given the opportunity to engage, people begin to feel strongly and passionately about the issue of social care reform.²³⁷

131. Engaging the public in the reform process will be critical to its success. *The Government should commit to a public engagement process, which builds the public’s understanding of social care and the challenges it faces and explain why reform is needed. This is an essential step in gaining public support for proposals which are going to ask them to pay more in order to improve the system. This must be supplemented by the publication of clear and comprehensible costings of different funding options, which are communicated in a clear, impartial, and jargon-free way to the general public.*

132. Engaging with people receiving social care, carers, relatives and care workers, and others with a stake in the outcome of the reforms, throughout the reform process is also critical. This will help to ensure an outcome that meets people’s needs, receives their backing and, ultimately, has the best chance of success. A Parliamentary Commission, although primarily focused on the funding mechanisms, could also play a role in engaging the public and stakeholders.

236 Institute for Government ([FSC0163](#))

237 [Q51](#) and [Q25](#)

Conclusions and recommendations

The state of social care

1. Authoritative sources in the social care sector say that, despite the additional funding, there will be a funding gap of £2.2–£2.5 billion in 2019–20. Before further reform of the system can be contemplated, the funding gap must be closed. Upfront funding will also be needed for transformation issues. The issue of backdated pay for sleep-ins also presents an immediate risk to organisations' financial stability and must be addressed urgently. (Paragraph 20)
2. Before further reform of the system can be contemplated, the funding gap must be closed. Upfront funding will also be needed for transformation issues. (Paragraph 20)
3. The combination of rising demand and costs in the face of reductions in funding has placed the social care system under very great and unsustainable strain. In its present state, the system is not fit to respond to the demographic trends of the future. Of greatest concern, is the fact that the very people the system is there to support get only the care they need to survive, rather than the care they need to live full and independent lives. (Paragraph 30)

Principles for funding social care

4. After successive attempts at reform, and in the context of an unrelenting increase in demographic pressures, the social care Green Paper must be the catalyst for achieving a fair, long-term and sustainable settlement. (Paragraph 30)

5. Principle 1—Good quality care:

Funding should be sufficient to achieve the aims of social care, which are to promote a person's wellbeing, independence and dignity, and enable them to exercise choice and control over the way they live their life. This will require universal provision of high quality, personalised care delivered by a stable well-paid and well-trained workforce alongside well-supported carers to a wider group of people than currently receives care, all within a navigable and accessible system. It should also aim to address the current levels of unmet and under-met need. (Paragraph 36)

6. Principle 2—Considering working age adults as well as older people:

The social care Green Paper is focusing on older people. However, provision of care for working age adults amounts to over half of all spending on social care and is set to grow in future years. To be sustainable, reforms to social care funding, including decisions on where the funding should come from, need to take into account the costs of meeting the needs of working age adults. At the very least, the Green Paper should be closely linked with the parallel programme for working age adults, clearly setting out how its proposals impact on funding for that age group. The Green Paper should consider both. (Paragraph 38)

7. Principle 3—Ensuring fairness between the generations:

Intergenerational fairness needs to be addressed. Contributions towards the cost of care should be fairly distributed between generations. Some older people who stand to be the main beneficiaries of increased spending on social care may be relatively wealthy, with housing assets, savings and pensions, compared to younger generations. Young people often face higher housing costs, less stable employment and less generous pensions, and may be paying back student loans or have family commitments. Life expectancy has increased, which is a cause for celebration, but which again has implications for the balance of contributions between different age groups. Working age employed adults are a shrinking proportion of the total adult population. For these reasons, older people could be expected to continue, while taking into account the fact that they have contributed throughout their working lives via taxation. However, over the longer term, the distribution of wealth between the different age groups may change, with corresponding implications for fairness, suggesting that a flexible solution is required. (Paragraph 40)

8. Principle 4—Aspiring over time towards universal access to personal care free at the point of delivery:

Currently, the burden of the cost falls on individuals in an unfair distribution depending on diagnoses—particularly those paying for dementia care, the costs of which can be extremely high. The balance needs to be redressed, aspiring over time and moving towards, as funding permits, universal access to sustainably funded social care, free at the point of delivery. (Paragraph 42)

9. Principle 5—Risk pooling—protecting people from catastrophic costs, and protecting a greater portion of their savings and assets:

People want to be protected from the lottery of incurring catastrophic care costs, and to feel secure that they will be able to keep a greater proportion of their savings and assets. A cap on the amount of care costs a person paid would pool the risk, distributing the costs of very high care needs across the society. The level of protection (and therefore the costs of this policy) would depend on the level at which the cap is set, and determining this figure requires financial modelling and extensive consultation. Raising the means test threshold (the ‘floor’) is another way of enabling people to keep a greater proportion of their assets; again, the costs would be shared across society. Providing free at point of delivery care for those assessed as having critical or substantial care needs would be another way of protecting people from this risk. (Paragraph 44)

10. Principle 6—‘Earmarked’ payments:

People are generally willing to contribute more to pay for social care if they can be assured that the money will be spent on this purpose. ‘Earmarking’ taxation can help to give confidence and accountability over spending. (Paragraph 46)

Options for funding social care

11. A significant amount of extra funding is needed to maintain provision of social care at its current level, in the order of many billions of pounds over the next ten to twenty years. However, to ensure good care and a stable and quality workforce, the level of funding required may be much higher. (Paragraph 73)
12. *Costings of future provision of social care need to begin with a clear articulation of what good care looks like and costs for both older adults and working age adults—simply extending the current, inadequate provision of social care to more people is not a tenable long-term position. The Care Act 2014 provides a basis for determining good care. The starting point for the reform process must be to build on this, determining—in conjunction with service users, carers, care providers and care workers—what good care entails.* (Paragraph 74)
13. *In the long term, an independent body should be tasked with modelling the amount of funding needed by social care in the future and ensuring funding keeps pace with need, providing the Government with two yearly forecasts of needs and funding requirements.* This is in line with the recommendation made by the House of Lords Committee on the Long-term Sustainability of the NHS for an independent ‘Office for Health and Care Sustainability’ to advise on all matters relating to the long-term sustainability of health and social care. (Paragraph 75)
14. Many commentators expressed the view that if we were beginning with a ‘clean sheet of paper’, it is unlikely that we would design the current system of divisions between health and social care. The difficulties with Continuing Healthcare (CHC) funding—the system through which social care is paid for by the NHS for a small number of people with high health and social care needs—illustrate the problems of setting a hard boundary between health and social care. Only around half of those who apply for CHC funding eventually get it, decision making about eligibility is inconsistent across the country, and the ‘cliff edge’ between those who qualify and those who do not has been an ongoing source of distress for families, as well as leading to costly and distressing appeals and legal challenges. (Paragraph 76)
15. While some of the evidence we received supported the idea of a social care system free at the point of use, like the NHS, others felt that a balance of responsibility between the state and the individual was appropriate. Our Citizens’ Assembly members expressed strong support for a social care system that was free at the point of use, like the NHS. Clearly, funding a social care system entirely free at the point of use would increase costs substantially and is unlikely to be affordable immediately. However, we support the provision of social care free at the point of delivery as a long-term direction of travel. *In principle, we believe that the personal care element of social care should be delivered free at the point of use to everyone who has the need for it, but that accommodation costs should continue to be paid on a means-tested basis. The aim should be to work to achieve this ideal and to see a gradual transfer of financial responsibility for social care away from the individual at the point of need, making it free at the point of delivery. This should begin by extending free personal care to those deemed to have ‘critical’ needs. However, particularly for younger adults, it is essential that social care is viewed more holistically and funding for ‘preventative’ social care for adults with moderate social care needs is reinstated.* (Paragraph 77)

16. We recommend that people who receive social care should be allowed to receive direct cash payments to enable them to pay carers, including family carers, to help those families who prefer to care for loved ones themselves at home. (Paragraph 78)
17. There is a clear need for increased funding for social care. *Given the scale of the additional funding likely to be needed, a combination of different revenue-raising options will need to be employed, at both a local but also a national level.* Combining different revenue streams also has the advantage of enabling a more tailored approach, with people contributing to social care in different ways at different points in their lives. (Paragraph 88)

At local level:

18. *There should be a continuation for the foreseeable future of the existing local government revenue streams. In 2020, these funding streams should be enhanced through 75% business rate retention. This should be used to fund social care rather than the replacement of grants the Government is proposing to introduce.* While business rates revenue is poorly matched with social care funding needs, it is a source of funding expected to come to councils in 2020. We welcome the fact that the Government is currently working to review and update the formula which determines how revenue is redistributed according to need. (Paragraph 89)
19. *In the medium term, there should be a reform of the council tax valuations and bands to bring them up-to-date.* (Paragraph 90)
20. In the future, as other funding streams develop, the contribution from council tax and business rates to social care funding could reduce, allowing councils to better fund other important services. (Paragraph 91)

At a national level:

21. Local government funding will only ever be one part of the solution for social care, and it is clear that extra revenue will also need to be raised nationally. (Paragraph 92)
22. We heard strong support for the principle of earmarking tax—it was felt that establishing a visible fund for people to contribute to that is clearly, transparently and accountably linked to spending on social care is key to gaining public acceptance for this measure. The proposals for a long-term care insurance scheme in Germany won support from the public there for similar reasons. (Paragraph 93)
23. *We therefore recommend that an earmarked contribution, described as a ‘Social Care Premium’, should be introduced, to which individuals and employers should contribute. This can either be as an addition to National Insurance, or through a separate mechanism similar to the German model. The Social Care Premium could be managed by central government, and audited by the National Audit Office, or managed separately by a statutory body or not for profit insurance based funds, as is the case in Germany.*
 - To ensure the accountability desired by the public, we believe that the funding derived from the Social Care Premium should be placed in an appropriately named and dedicated fund. The fund should be regularly audited and required to publish its spending and accounts.

- We suggest that the National Audit Office could perform this function and report its findings annually to Parliament. We were attracted by the visibility afforded by the German social care insurance system, and it is with this in mind that we make this recommendation. We believe that the fund we are proposing would demonstrate to the public that the Government has accepted that the need for social care is a risk requiring protection.
 - Following our principle of fairness between generations, we recommend that those aged under 40 should be exempt from the Social Care Premium, and that it should also be paid by those over the age of 65.
 - Specific consideration should be given to setting a minimum earnings threshold for the Social Care Premium—to protect those on the lowest incomes—and to lifting the maximum threshold for such payments (currently set at £46,350 per year).
 - Consideration should also be given to including unearned income, for example pensions and investments, in contribution calculations. The way in which self-employed people pay National Insurance should also be reformed to ensure they pay equivalent contributions.
 - As a further development, the principle of having an earmarked fund that the public could see is for social care could be extended to funding of the NHS, providing a consistency and coherence to the link between social care and the NHS, underpinned by closer working and integration at a local level. In the long term, we believe there is a strong case for reimagining this as ‘National Health and Care Insurance’.
 - There would also need to be consideration of the means for assessment of need and a mechanism for increasing the required premiums to meet changes in demand over time. Wherever possible, these mechanisms should be independent statutory bodies to remove the short-term political cycles and decision-making from the process. This task could be undertaken by the independent body to which we refer in Paragraph 75 above. (Paragraph 94)
24. *In addition, in order to remove the catastrophic cost of social care for some people, and to spread the burden more fairly, we also recommend that a specified additional amount of Inheritance Tax should be levied on all estates above a certain threshold and capped at a percentage of the total value, and the monies raised used to support the relevant funds as described above, until the level of the Social Care Premium meets demand unaided.* (Paragraph 95)

Chapter 4: Social care and its wider context—health, public health and housing

25. *We recommend that local attempts to better integrate services continue apace.* (Paragraph 100)
26. *There is a strong case for the local delivery of social care at a local level—this brings the important benefits of links with housing and other local services, as well as local accountability. Better integration of health and social services is key, and the potential*

of Health and Wellbeing Boards, as well as new arrangements including integrated care systems, organisations and partnerships, should be used to the maximum to support integration. (Paragraph 104)

27. *Given the interdependencies between the provision of health care, social care, and also public health, we recommend that in its discussions of future funding settlements the Government should consider all these in the round. (Paragraph 107)*
28. *The Green Paper must give due prominence and consideration to the role of housing as a key determinant of health and wellbeing and consequently need for health and social care support. In particular, it should consider how, through improvements, adaptations and wider access to specialist housing, we can ensure that the home environment better aids health and wellbeing and the delivery of social care, and how to facilitate this through better integration of social care, health and housing services. (Paragraph 111)*

Political and public consensus on social care

29. A cross-party approach on reforming social care funding is essential if we are to achieve final and lasting reform. There has been a failure in the past to make progress on reform, resulting from the use of unhelpful, party political terms like ‘death tax’ and ‘dementia tax’ which could have been curbed by a cross-party approach. This issue is unlikely ever to be fairly addressed in the midst of an election campaign. Furthermore, such an approach would also help to guard against partisan political interference after the reforms have been implemented. (Paragraph 119)
30. The concept of a cross-party parliamentary commission currently has the support of more than 100 MPs from all English political parties. *As a proven mechanism for building and maintaining political consensus on difficult issues, and following other unsuccessful attempts at reform, we strongly recommend that a parliamentary commission offers the best way to make desperately needed progress on this issue. We note the key elements of the Pensions Commission which led to its success— independence, timeliness, engagement with key stakeholders and the public, and transparency. (Paragraph 126)*
31. *Using the principles set out in this report as a basis for proceeding, a parliamentary commission should look at the specific proposals we are making, together with the recommendations made in the Green Paper, in order to determine the mechanisms which will provide a long-term funding solution for social care. To ensure the systems are properly joined up and a ‘whole systems’ approach to funding reform is taken into account, the parliamentary commission should also look at how the funding for social care relates to funding for health and public health. (Paragraph 127)*
32. Engaging the public in the reform process will be critical to its success. *The Government should commit to a public engagement process, which builds the public’s understanding of social care and the challenges it faces and explain why reform is needed. This is an essential step in gaining public support for proposals which are going to ask them to pay more in order to improve the system. This must be supplemented*

by the publication of clear and comprehensible costings of different funding options, which are communicated in a clear, impartial, and jargon-free way to the general public. (Paragraph 131)

33. Engaging with people receiving social care, carers, relatives and care workers, and others with a stake in the outcome of the reforms, throughout the reform process is also critical. This will help to ensure an outcome that meets people's needs, receives their backing and, ultimately, has the best chance of success. A Parliamentary Commission, although primarily focused on the funding mechanisms, could also play a role in engaging the public and stakeholders. (Paragraph 132)

Annex: Note of visit to New Deanery Care Home, Braintree

On 16 April 2018, the Members of two committees attended a focus group at New Deanery Care Home in Braintree, Essex. They heard from recipients of social care, family, carers, care workers and care home administrators. They heard about issues relating to social care funding from the perspective of both older adults and working age adults.

The Committees were represented by the following Members:

- Dr Sarah Wollaston MP, Chair of the Health and Social Care (HSC) Committee
- Andrew Selous MP HSC Committee
- Helen Hayes MP, Housing, Communities and Local Government (HCLG) Committee
- Mark Prisk MP, HCLG Committee
- Liz Twist MP, HCLG Committee

The Committees are extremely grateful to all those who participated and who spoke so honestly about their experiences. The Committee would also like to thank Julia Clinton, CEO of Sonnet Care Homes, for her assistance in organising the visit, as well as staff from the Parliamentary Outreach team.

Navigating the system

Difficulties in navigating the system was a strong theme raised by the focus groups. Individuals who had organised care for their loved ones described their experiences in stark terms:

There was no assistance, no guidance about where to go. I just got in my car and went to look.

When my wife was diagnosed with dementia, we expected someone to say, "This is what you do". It was like having a jigsaw puzzle with no picture on the box. Some kind of route map to tell you what's available would be helpful.

I went through social services to get help with mum—barrier after barrier—I was shocked at the lack of help. There is no continuity—I was passed from pillar to post. It was very stressful for our family, and I'm in the care sector, I know who to go to

They need to help us how to get through the system. It's a nightmare. A dark tunnel

When my father-in-law was diagnosed, he was given a pack of lots of organisations to help. But my mother-in-law couldn't help. It all slipped through the net. You need a kind of buddy, someone to stay around to help.

Care home workers agreed:

One of the biggest issues is lack of knowledge. Some kind of education for families would lessen the impact. People come to us not knowing about anything—they don't know what they're looking for, who to speak to

The complexity of assessments and lack of support in dealing with this were also raised, with people pointing out that a lot is online, which may be very difficult for certain groups to access:

Questions on assessment form are so complex and there is nobody to talk to about this. Most guidance and support available online but not everybody can be 'online'

The system is confusing even if you know the system- all the types of allowances that have to be or can be claimed.

There are lots of applications and a lot is online—what can I claim for? what do I qualify for? There is no one to talk to about this.

Forms are confusing and complex

Simpler language is needed

It was felt that this could lead to people missing out on sources of funding that they might be eligible, simply because they are not aware of its existence.

Some attendees reported that most of the information available was aimed at older people, rather than working age adults

Care home staff also felt that the paperwork involved in the current system was cumbersome:

The amount of paperwork generated by care homes is huge. There must be alternative—a large amount of time spent on paperwork rather than caring.

People suggested that there should be a single place—not online—or a point of contact, like a care navigator—to offer people advice or guidance. GPs should be equipped to signpost people towards these sources of support, as they are often the first point of call when someone begins to develop care needs.

One attendee, however, argued that the system itself should be simplified:

Why not just make system simpler, rather than having people to tell you how to navigate it?

Pressure on family carers

Many of the relatives who attended the focus group had experience of caring for their loved ones at home before they became care home residents, and described the importance of respite care:

I did get some help from social services who sent two people once a week for a few hours, so I could have a break—I used to go and play golf. Then, due to sickness, they didn't come for three weeks and I couldn't cope. Social services were brilliant and rung around and found a bed within in a day. They offered a week's respite, then another and then a permanent home. I have a lot of respect for them, I think they saved my life. When you get through to them finally, they are very helpful indeed.

One attendee described great difficulties in getting respite care, even to give teenage children time off from caring responsibilities once a week for their working-age adult parent. Not providing such care can be a false economy as without it carers cannot cope and people need to go into residential care sooner:

You may just need someone to keep a loved one company or take them for coffee but this isn't funded and very expensive. Give teenage children some time off once a week but this is very limited. If council wants to limit full time care costs then more of these facilities need to be provided.

Care home staff also report immense strain on families caring for loved ones at home:

By the time people come to us, they are exhausted. You get very sick carers in the community. That is much more of a problem. They are older—you will have an 85-year-old woman caring for her husband. It's a tick box for social services—she lives with husband therefore needs less care. It's just the pressure they are under.

One attendee pointed out the hidden cost to the economy of people caring for loved ones themselves:

If you were able to add up the lost revenue from carers, you would find the bill reduces significantly.

Quality of social services

Participants described issues with the quality of social care they and their relatives received. One participant felt that the local authority funded care homes were poor quality and so chose to fund his grandmother's care himself, despite having other financial commitments:

Nan has no money so we had to fund her. I have two kids, a house etc. Everyone asks why we didn't chose a social services place. It's because they are so awful—just people waiting to die. The buildings are so old—up and down—she wouldn't have coped. I'm getting stung for my nan. We're [younger people] getting it down the line as well.

Another participant observed that

The cost of care home does not always reflect the quality. We visited 17—the difference between them didn't equate to cost.

Care workers felt that better use of technology could improve care:

We need to find ways of using assistive technology to help. There aren't going to be enough people working in care in the future. But there is nothing on the market that eliminates need to write stuff down. It's a big logistical nightmare to go from paper to electronic.

However, one family member observed that even low tech equipment is difficult to obtain:

The social workers couldn't get the things we needed. We struggled for two weeks to get a toilet raiser, despite it being flagged up as an urgent need—it's a basic piece of kit.

Relatives of working age adults with social care needs argued that these needs are very different from older people's needs, including physical activity and stimulation, but that stimulating social activities were often not funded by local authorities. One participant described being offered one day a week subsidised daycare, but having to find funds herself for a second day, which at £95 was very expensive. Others agreed that they had to limit use of such facilities due to affordability.

Care staff told us that they are not able to provide full, stimulating care for working age adults who need residential care, and fees paid by local authorities have become unsustainably low, as there have been no fee increases for four years.

Continuing healthcare funding

Participants talked compellingly about their experiences negotiating continuing healthcare funding:

A gulf exists between what's NHS and what's not—the untold riches of CHC versus means tested social care. I would rather we were honest and say, "There's not enough money". My wife was finally granted CHC funding in the last two weeks of life when she was completely bedridden and unable to do anything. It's partly that dementia is such an enormous social problem that there is simply not enough funding to treat it as a disease. If it were cancer, there would be no question about the funding for it.

They described long delays for CHC funding appeals, and one participant argued that:

There is an artificial distinction between health and social care—if the total budget was used to fund the total spectrum of care—if we had care in a seamless spectrum—it wouldn't matter. We should abolish the artificial distinction and chasm in approaches to funding.

One participant argued that there was poor integration between the NHS and social care, and also within the NHS itself:

The NHS and local government do not work together well. This needs addressing. The NHS is structured in a way where you have so many divisions.

Paying for care

Participants expressed a range of views about paying for care. Anger and disappointment at having to sell their homes and not have a legacy to leave future generations were a common theme:

My parents helped me and I would like to help my children. When my husband died, my income dropped and I could no longer take care of myself after about 6 months. I had to sell my house to get in here and I wanted to leave it to my children. I was concerned about what would happen if I couldn't afford care anymore. But then I found out about threshold and I was told I wouldn't be turned out [of the care home]. My granddaughters are going to university. This is an ongoing concern. I read that by 2020 people would be able to keep their property but my property is gone.

I am angry that after [my husband] died I had to sell my house to come here. I was hoping that I could leave something to my children, as my parents did for me. There should be a blanket of help and funding across the country—apparently, it's different from one county to another. I wonder whether councils spend their money wisely. What about the foreign aid budget, that could be cut? This situation has been coming on for 10 years or more.

It's not fair that we have to sell our properties to fund ourselves to be taken care of.

I speak as a carer and a care provider. My father had a stroke. My parents worked all their lives, did everything right for years. Now he is frightened. What's going to happen? Will he have to sell his home? It feels like you're penalised

I have three children in 30s. Their incentive to purchase a house has been demoralised by seeing their grandparents having to sell their house to pay for care. I don't know how to advise them.

My parents had to pay to top-up my grandmother's care. That distressed her and she was unable to leave anything to her children

Some people felt that they would prefer to pay increased taxes to fund social care:

I would prefer to pay the extra tax now so it's already covered. I would prefer for it to come out of NI, and you would have it for yourself to fall back in. Now, my kids are losing out. I would prefer to pay extra, knowing you actually get the service.

I agree. It's like the pension. I should have been paying in ages ago.

Compulsory contribution into something might work. But I think people will be sceptical about throwing money into the pit as it's difficult to challenge the NHS. Radical reform of the system is needed People would be willing to pay if the money was hypothecated to care they are going to get. If someone told me I had to pay an extra penny on income tax for the NHS, I wouldn't like it, but I would like hypothecated social insurance.

Some people argued that a cap on care costs would be an improvement on the current situation, but pointed out that the cap would have to be very high for people not to lose their home. One participant suggested that equity release schemes could be used to fund people's costs up to the level of a cap, allowing people to stay in their own homes. Participants questioned the current threshold level of £23,250, and felt it should be raised, given how long ago it was set, and how low it was.

Other funding options were also discussed:

I don't think retired people should pay as they have paid throughout their lives. But, if they are very well-off, then yes.

If you have assets, you are taxed. People are retiring later so there is still a significant base of tax payers. People would contribute more if they felt it wasn't being wasted. Other countries have found a way to do it without taxation and they have done it using the private sector.

With an insurance system, people know that what they paid for is what they get. Nobody objects if they know what they're going to get.

When you're young, you don't think about the future. If something was in place that made us pay and paying it was just a given, it would be better. Maybe start at the age of 40. People are having families later, their children are going to have quite elderly parents.

Finally, one participant argued that self funders subsidised users of social care being funded by the local authority:

If you're self-funding and live in the same home as people with dementia paid for by social services, you are subsidising them.

Formal minutes

Tuesday 19 June 2018

The Housing, Communities and Local Government and Health and Social Care Committees met concurrently, pursuant to Standing Order No. 137A.

Members present:

Housing, Communities and
Local Government Committee

Mike Amesbury

Mr Clive Betts

Helen Hayes

Kevin Hollinrake

Andrew Lewer

Jo Platt

Mr Mark Prisk

Mary Robinson

Liz Twist

Matt Western

Health and Social Care Committee

Luciana Berger

Ben Bradshaw

Rosie Cooper

Andrew Selous

Martin Vickers

Dr Paul Williams

Dr Sarah Wollaston

Clive Betts was called to the Chair (Standing Order No.137A (1)(d)).

Draft Report (*Long-term funding of adult social care*) proposed by the Chair, brought up and read.

Ordered, That the Chair's draft Report be considered concurrently, in accordance with Standing Order No. 137A(1).

Ordered, That the Chair's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 132 read and agreed to.

Summary agreed to.

Annex agreed to.

HOUSING, COMMUNITIES AND LOCAL GOVERNMENT COMMITTEE

The Health and Social Care Committee withdrew.

Mr Clive Betts, in the Chair

Mike Amesbury	Mr Mark Prisk
Helen Hayes	Mary Robinson
Kevin Hollinrake	Liz Twist
Andrew Lewer	Matt Western
Jo Platt	

Draft Report (*Long-term funding of adult social care*), proposed concurrently by the Housing, Communities and Local Government Committee and the Health and Social Care Committee, brought up and read.

Resolved, That the draft Report prepared by the Housing, Communities and Local Government and Health and Social Care Committees be the Seventh Report of the Committee to the House.

Ordered, That the provisions of Standing Order No. 137A(2) be applied to the Report.

Ordered, That the Chair make the Joint Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned until Wednesday 20 June at 9.15 a.m.]

HEALTH AND SOCIAL CARE COMMITTEE

The Housing, Communities and Local Government Committee withdrew.

Dr Sarah Wollaston, in the Chair

Luciana Berger Andrew Selous

Ben Bradshaw Martin Vickers

Rosie Cooper Dr Paul Williams

Draft Report (*Long-term funding of adult social care*), proposed concurrently by the Housing, Communities and Local Government Committee and the Health and Social Care Committee, brought up and read.

Resolved, That the draft Report prepared by the Housing, Communities and Local Government and Health and Social Care Committees be the Ninth Report of the Committee to the House.

Ordered, That the provisions of Standing Order No. 137A(2) be applied to the Report.

Ordered, That Mr Clive Betts make the Joint Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned until Tuesday 26 June at 2.00pm.]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Monday 26 March 2018

Caroline Abrahams, Charity Director, Age UK, **Dominic Carter**, Senior Policy Manager, Alzheimer's Society, **Neil Heslop**, Chief Executive, Leonard Cheshire Disability, and **Anna Bird**, Executive Director of Policy and Research, Scope [Q1–33](#)

Simon Bottery, Senior Fellow in Social Care, King's Fund, **Nick Davies**, Associate Director, Institute for Government, **Sir Andrew Dilnot**, Chairman of 2011 Commission on the Funding of Care and Support, **Professor Martin Knapp**, Director of Personal Social Services Research Unit, London School of Economics [Q34–61](#)

Tuesday 24 April 2018

Douglas Cooper, Project Lead, Competition and Markets Authority, **Professor Martin Green OBE**, Chief Executive, Care England, **Andrea Sutcliffe CBE**, Chief Inspector of Adult Social Care, Care Quality Commission, and **Jules Constantinou**, President-elect, Institute and Faculty of Actuaries [Q62–99](#)

Sarah Pickup, Deputy Chief Executive, Local Government Association, and **John Jackson**, Co-Lead, Resources Policy Network, Association of Directors of Adult Social Care [Q100–141](#)

Simon Stevens, Chief Executive, NHS England [Q142–174](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

FSC numbers are generated by the evidence processing system and so may not be complete.

- 1 #SolveSleepInsAlliance ([FSC0162](#))
- 2 38 Degrees ([FSC0141](#))
- 3 Action on Hearing Loss ([FSC0106](#))
- 4 ADASS ([FSC0116](#))
- 5 Adrian Venditti ([FSC0054](#))
- 6 Age UK ([FSC0182](#))
- 7 Alzheimer's Society ([FSC0158](#))
- 8 Analysis of Individual Submissions to the Parliamentary Office of Science and Technology ([FSC0195](#))
- 9 Anchor, Hanover and Housing and Care 21 ([FSC0181](#))
- 10 Andrew Pickersgill ([FSC0177](#))
- 11 ANEC ([FSC0130](#))
- 12 Anonymous ([FSC0003](#))
- 13 Anonymous ([FSC0026](#))
- 14 Anonymous ([FSC0032](#))
- 15 Anonymous ([FSC0166](#))
- 16 Association of British Insurers ([FSC0179](#))
- 17 Association of Directors of Public Health ([FSC0037](#))
- 18 Barnsley Metropolitan Council ([FSC0149](#))
- 19 Baroness Sally Greengross ([FSC0065](#))
- 20 Birmingham City Council ([FSC0113](#))
- 21 BIVDA ([FSC0071](#))
- 22 British Geriatrics Society ([FSC0095](#))
- 23 Buckinghamshire County Council ([FSC0070](#))
- 24 Bupa UK ([FSC0144](#))
- 25 Care & Repair England ([FSC0063](#))
- 26 Care and Support Alliance ([FSC0180](#))
- 27 Care England ([FSC0048](#))
- 28 Care Quality Commission (CQC) ([FSC0171](#))
- 29 Carers Trust ([FSC0069](#))
- 30 Carers UK ([FSC0143](#))
- 31 Chartered Institute of Housing ([FSC0027](#))
- 32 Cicely Saunders Institute of Palliative Care, Policy and Rehabilitation ([FSC0068](#))
- 33 CIPFA ([FSC0060](#))

- 34 City, University of London ([FSC0014](#))
- 35 CMA ([FSC0172](#))
- 36 Collette Higgins ([FSC0159](#))
- 37 County Councils Network ([FSC0118](#))
- 38 Coverage Care Services ([FSC0156](#))
- 39 Demos ([FSC0148](#))
- 40 Department of Health and Social Care and the Ministry of Housing, Communities and Local Government ([FSC0137](#))
- 41 Devon County Council ([FSC0135](#))
- 42 Diana Wynter ([FSC0079](#))
- 43 Diane Kivi ([FSC0021](#))
- 44 Dimensions ([FSC0099](#))
- 45 District Councils Network ([FSC0151](#))
- 46 Dr Fraser Old ([FSC0031](#))
- 47 Dr Jaqueline Meeks ([FSC0161](#))
- 48 Dr John Dean ([FSC0129](#))
- 49 Dr John Tacon ([FSC0022](#))
- 50 Dr Malcolm Perkin ([FSC0023](#))
- 51 Dr Martin Fieldhouse ([FSC0067](#))
- 52 Dr Val Brooks ([FSC0075](#))
- 53 East Sussex County Council ([FSC0012](#))
- 54 Elizabeth Balsom ([FSC0041](#))
- 55 Emerita Professor Caroline Glendinning ([FSC0091](#))
- 56 Equity Release Council ([FSC0097](#))
- 57 Essex County Council ([FSC0169](#))
- 58 Fabian Society ([FSC0190](#))
- 59 Future Care Capital ([FSC0092](#))
- 60 Gateshead Council ([FSC0134](#))
- 61 Gill Comley ([FSC0128](#))
- 62 Harry Hemus ([FSC0186](#))
- 63 HC-One ([FSC0142](#))
- 64 Healthwatch Torbay ([FSC0188](#))
- 65 Herefordshire Council ([FSC0089](#))
- 66 Hertfordshire Co-Production Board ([FSC0102](#))
- 67 Hft ([FSC0150](#))
- 68 Homeless Link ([FSC0127](#))
- 69 Horizon Senior Care Ltd ([FSC0007](#))
- 70 Housing Learning and Improvement Network ([FSC0080](#))

- 71 Inclusion London ([FSC0108](#))
- 72 Independent Age ([FSC0165](#))
- 73 Institute and Faculty of Actuaries ([FSC0126](#))
- 74 Institute and Faculty of Actuaries ([FSC0193](#))
- 75 Institute for Government ([FSC0163](#))
- 76 Jim Gatten ([FSC0084](#))
- 77 John Pickin ([FSC0176](#))
- 78 Keep Our NHS Public (Cornwall) ([FSC0078](#))
- 79 Kelvin Debideen ([FSC0001](#))
- 80 Kent County Council ([FSC0112](#))
- 81 Kerry Davies ([FSC0057](#))
- 82 Knowsley MBC ([FSC0125](#))
- 83 Lancashire Care Association Co. Ltd ([FSC0119](#))
- 84 Later Life Ambitions ([FSC0178](#))
- 85 Learning Disability England ([FSC0064](#))
- 86 Leonard Cheshire Disability ([FSC0101](#))
- 87 Lifeways ([FSC0131](#))
- 88 Local Government Association ([FSC0191](#))
- 89 London Borough of Havering ([FSC0175](#))
- 90 M Brown ([FSC0006](#))
- 91 Malcolm King ([FSC0024](#))
- 92 Merton Centre for Independent Living ([FSC0185](#))
- 93 MHA ([FSC0114](#))
- 94 Motor Neurone Disease Association ([FSC0045](#))
- 95 Mr Alan Bourne ([FSC0170](#))
- 96 Mr Alan Fenwick ([FSC0028](#))
- 97 Mr Andrew Jones ([FSC0123](#))
- 98 Mr Ernest Davies ([FSC0077](#))
- 99 Mr Ernie Holden ([FSC0002](#))
- 100 Mr Jeremy Pickard ([FSC0025](#))
- 101 Mr Jim Diamond ([FSC0030](#))
- 102 Mr John Banks ([FSC0154](#))
- 103 Mr John Wilson ([FSC0062](#))
- 104 Mr Marc Wharton ([FSC0085](#))
- 105 Mr Michael Bainbridge ([FSC0090](#))
- 106 Mr Nicholas Murphy ([FSC0040](#))
- 107 Mr Peter Donaldson ([FSC0018](#))
- 108 Mr Ronald Carey ([FSC0038](#))

- 109 Mr S Cadney ([FSC0133](#))
- 110 Mr Shouvik Datta ([FSC0086](#))
- 111 Mr Stephen Gregory ([FSC0019](#))
- 112 Mr Trevor Durham ([FSC0074](#))
- 113 Mrs Amanda Banks ([FSC0044](#))
- 114 Mrs Angela De Vorchik ([FSC0076](#))
- 115 Mrs Carol Comey ([FSC0103](#))
- 116 Mrs Deborah Chope ([FSC0047](#))
- 117 Mrs Genevieve Stone ([FSC0053](#))
- 118 Mrs Jocelyn Hanson ([FSC0146](#))
- 119 Mrs Juliet Chalk ([FSC0034](#))
- 120 Mrs Kerrie-Anne Barnes ([FSC0081](#))
- 121 Mrs Margaret Sheather ([FSC0042](#))
- 122 Mrs Moya Gordon ([FSC0160](#))
- 123 Mrs Susan Gee ([FSC0033](#))
- 124 Ms Elaine Smethurst ([FSC0056](#))
- 125 Ms Jill Pateman ([FSC0020](#))
- 126 Ms Judith Flinn ([FSC0110](#))
- 127 Ms Sue Binns ([FSC0046](#))
- 128 Ms Susan Lane ([FSC0100](#))
- 129 National Care Association ([FSC0183](#))
- 130 National Housing Federation ([FSC0155](#))
- 131 National Institute for Health and Care Excellence ([FSC0013](#))
- 132 National Pensioners Convention ([FSC0017](#))
- 133 NHS England ([FSC0192](#))
- 134 NHS Providers ([FSC0147](#))
- 135 Norfolk County Council ([FSC0120](#))
- 136 North West ADASS ([FSC0093](#))
- 137 North Yorkshire County Council ([FSC0138](#))
- 138 Nottingham City Council ([FSC0107](#))
- 139 Papworth Trust ([FSC0189](#))
- 140 Parkinson's UK ([FSC0058](#))
- 141 Peter Fox ([FSC0073](#))
- 142 Professor Caroline Glendinning and Mathew Wills ([FSC0194](#))
- 143 Professor Luke Clements ([FSC0015](#))
- 144 Professor Peter Beresford ([FSC0043](#))
- 145 Professor Ruth Hancock ([FSC0136](#))
- 146 Professor Ruth Hancock ([FSC0184](#))

- 147 Reform Research Trust ([FSC0124](#))
- 148 Registered Nursing Home Association ([FSC0140](#))
- 149 Robert Mackay ([FSC0167](#))
- 150 Rochdale Borough Council ([FSC0132](#))
- 151 Rosemary Laxton ([FSC0055](#))
- 152 Rotherham Metropolitan Borough Council ([FSC0153](#))
- 153 Royal Borough of Windsor and Maidenhead ([FSC0173](#))
- 154 Royal College of Occupational Therapists ([FSC0087](#))
- 155 Royal Mencap Society ([FSC0168](#))
- 156 Rural Services Network ([FSC0036](#))
- 157 Rutland County Council ([FSC0109](#))
- 158 Scope ([FSC0016](#))
- 159 Sense ([FSC0011](#))
- 160 SIGOMA ([FSC0050](#))
- 161 Simplyhealth ([FSC0187](#))
- 162 Skills for Care ([FSC0164](#))
- 163 Social Care Institute for Excellence ([FSC0061](#))
- 164 Society of County Treasurers (SCT) ([FSC0083](#))
- 165 South East England Councils ([FSC0098](#))
- 166 Suffolk County Council ([FSC0105](#))
- 167 Sylvia Stanbridge ([FSC0157](#))
- 168 The Challenging Behaviour Foundation ([FSC0117](#))
- 169 The Guinness Partnership ([FSC0111](#))
- 170 The Health Foundation and The King's Fund ([FSC0145](#))
- 171 The King's Fund ([FSC0174](#))
- 172 The Local Government Association ([FSC0049](#))
- 173 The Royal College of Ophthalmologists ([FSC0008](#))
- 174 The Salvation Army ([FSC0115](#))
- 175 The Shelford Group ([FSC0066](#))
- 176 Uma Satkunam ([FSC0029](#))
- 177 UNISON ([FSC0096](#))
- 178 United for All Ages ([FSC0010](#))
- 179 United Kingdom Homecare Association (UKHCA) ([FSC0059](#))
- 180 University College London Institute of Epidemiology and Health Care ([FSC0052](#))
- 181 Voluntary Organisations Disability Group ([FSC0039](#))
- 182 West Sussex County Council ([FSC0072](#))
- 183 Wigan Council ([FSC0122](#))

List of Reports from the Committees during the current Parliament

All publications from the Health and Social Care Committee are available on the [publications page](#) of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2017–19—Health and Social Care Committee

First Report	Appointment of the Chair of NHS Improvement	HC 479
Second Report	The nursing workforce	HC 353
Third Report	Improving air quality	HC 433 (HC 1149)
Fourth Report	Brexit: medicines, medical devices and substances of human origin	HC 392
Fifth Report	Memorandum of understanding on data-sharing between NHS Digital and the Home Office	HC 677
Sixth Report	The Government's Green Paper on mental health: failing a generation – First Joint Report of the Education and Health and Social Care Committees of Session 2017–19	HC 642
Seventh Report	Integrated care: organisations, partnerships and systems	HC 650
Eighth Report	Childhood obesity: Time for action	HC 882
First Joint Special Report	Children and young people's mental health—the role of education: Government Response to the First Joint Report of the Education and Health Committees of Session 2016–17	HC 451

All publications from the Housing, Communities and Local Government Committee are available on the [publications page](#) of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2017–19—Housing, Communities and Local Government Committee

First Report	Effectiveness of local authority overview and scrutiny committees	HC 369 (Cm 9569)
Second Report	Housing for older people	HC 370
Third Report	Pre-legislative scrutiny of the draft Tenant Fees Bill	HC 583 (Cm 9610)
Fourth Report	Private rented sector	HC 440
Fifth Report	Business rates retention	HC 552
Sixth Report	Pre-legislative scrutiny of the draft Non-Domestic Rating (Property in Common Occupation Bill)	HC 943