

Evidence call: [Long term funding of Adult Social Care](#)

This response is provided by Prof Jon Glasby (University of Birmingham), Prof Matt Bennett and Prof Sue Yeandle (both University of Sheffield). It highlights (p2) the long-standing reform imperative in relation to adult social care (ASC) organisation and funding evidenced in work undertaken by Jon Glasby and Matt Bennett, with colleagues, as part of the ESRC-funded *Sustainable Care: connecting people and systems*<sup>1</sup> programme.

We briefly address the 4 questions set out in the Housing, Communities & Local Government Committee's call for evidence, based on our team's wider knowledge base, before summarising the key messages of their work.

Q1) *How has Covid-19 changed the landscape for long-term funding reform of the adult social care sector?*

Experience during the pandemic has sharply exacerbated financial pressures on providers and commissioners. There have been substantial additional costs (e.g. re shielding, infection control/protection, staffing, insurance, need for additional IT) and for some, especially in the residential care segment, significant loss of income (e.g. due to vacancies). These have been mitigated only partially by injections of additional government funds; cost pressures can be expected to remain high even as the pandemic subsides, or in a post-pandemic scenario.

Q2) *How should additional funds for the adult social care sector be raised?*

Internationally, funds for ASC are raised through various forms of taxation, compulsory LTC insurance and user charges, as well as incentive schemes to encourage private expenditure (e.g. on home adaptations, employing care staff, etc. by offering tax exemptions or rebates). All these options should be considered in detail and debated; several of them may need to be adopted. Controlling ASC costs through investment in prevention and in supporting people to combine paid work with unpaid care is also vital. (Unpaid carers provide the majority of care in all developed countries; due to population ageing, their ability to continue this depends on investment in relevant supports, e.g. through well-designed and effective work-care reconciliation policies).

Q3) *How can the adult social care market be stabilised?*

Strategies need short and longer-term elements. Short-term, government should meet the extra costs of the pandemic (e.g. help care businesses facing increases in insurance costs, or with severe occupancy deficits or staff shortages) and work with LAs/CQC to identify and support providers at risk of business failure/market exit.

Longer term, market stabilisation will not be achieved without tackling long-standing problems, including:

- workforce issues – in recruitment, retention, training, progression, recognition of skill/specialisation, working conditions and contractual arrangements, rewards (especially low pay); all care work should meet the ILO definition of 'decent work'.
- complexity and fragmentation in the care market: this impedes planning and leads to inequities (and potential care 'deserts') for people who need care and support;
- inefficiencies in commissioning processes, including duplication of effort
- difficulties in accessing care support and services: people who need support find this confusing and complicated, worry about its cost and quality, and struggle to obtain a good, timely and responsive mix of services (whether in the community, at home or in residential settings), technologies and adaptations;

Q4) *How can the adult social care market be incentivised to compete on quality and/or innovation?*

It is unlikely this can be achieved without public investment in the many small providers involved. This could begin with a new investment fund focussed on not-for profit and charitable care providers, linked to validated workforce development strategies and cooperation between these and other small ASC market businesses (focused on collaborative learning and sharing of specialised human/other resources).

ASC in England relies heavily on commercial businesses; new controls may be needed to limit profit extraction in larger or multinational businesses and to incentivise in-work progression practices and good working conditions.

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Adult Social Care funding and reform is explored in detail in the following published (open access) article:

Glasby, J., Zhang, Y., Bennett, M. R. and Hall, P. (2020) "[A lost decade? A renewed case for adult social care reform in England](#)" *Journal of Social Policy*, 1-32.

This provided a new analysis that developed Glasby et al.'s previous (2010) work with Downing Street and the Department of Health to review the costs of adult social care and the different options available to government in terms of reform.<sup>2</sup> That earlier work had concluded that the system was "broken" and that with no action the costs of adult social care could double within two decades if the pace of service improvement in 2010 (already strongly criticised for failing to fully and appropriately meet need) was maintained; costs would be significantly higher with no improvement.

Not only were these warnings not heeded, but the situation has since got worse. The new government instantly dropped its predecessor's proposed 2010 reforms and the austerity agenda that dominated the 2010s led to a 'lost decade' of spending cuts, service pressures and a growing sense of crisis; previous reforms and investment stalled and, in many cases, began to go backwards.

Despite the promise of the *Care Act 2014*, policy in the 2010s was even less ambitious than Glasby et al.'s 'slow uptake' scenario, presented to government (in 2010). The result was greater unmet and under-met need, more self-funding, lower quality care, a crisis among care providers, and much greater pressure on staff, families and partner agencies. Unless something significant now changes, current pressures will only increase, and the ASC system will become unsustainable.

Glasby et al's 2020 paper explores the relationship between future ASC spending and economic growth for 2020-60, based on three reform scenarios (see Tables 1 and 2). The analysis shows how the ASC cost projections are affected by conditions in the economy; it was conducted before the Coronavirus pandemic and ensuing economic recession, which makes action more urgent still (albeit harder to in practice than would have been the case before.)

We used Gross Value Added (GVA) as a proxy for government's financial capacity, and projected the ratio of gross spending on ASC to GVA. Our projections emphasise the importance of the government budget (economic growth) and early implementation of reforms when examining the sustainability of the ASC system. As the population ages, government's financial burden will increase, and available funds for implementing reform will decrease.

Between 1997 and 2018, gross spending on ASC in England accounted for 1.053% (1997) to 1.419% (2009) of total GVA. If the government maintains the current 'slow uptake' scenario (details of assumptions in Table 2), the share of gross spending on ASC to GVA will exceed 1.419% by 2031 (given 1% economic growth), 2028 (given 0.5% economic growth) and by 2026 (if economic growth remains at 2018 level).

The Covid-19 pandemic and recession exacerbate the pressures and urgency of ASC reform, but also make this harder in practice. The pandemic will significantly impact government's financial capacity to meet demand for ASC

Table 1: Projected gross spending on ASC by reform scenario	(£ millions, rounded)		
	2020	2040	2060
Scenario – 'solid progress' (costs of ASC constant)	18,121	20,162	21,292
Scenario – 'slow uptake' (costs of ASC assumed to increase by 2%)	18,853	31,170	48,913
Scenario – 'fully engaged' (costs of ASC assumed to decrease by 2%)	17,403	12,927	9,114

<sup>2</sup> Glasby, J., Ham, C., Littlechild, R. and McKay, S. (2010), The case for social care reform – the wider economic and social benefits (for the Department of Health/Downing Street), Birmingham: Health Services Management Centre/Institute of Applied Social Studies.

**Table 2: Details of the assumptions for reform scenarios (Glasby et al. 2020).**

**Slow uptake:** *future policy and practice remain as now, with periodic attempts to more fully integrate health and social care, but without sustained and real change; little permanent workforce reform; some support for carers; ongoing preventative/rehabilitative pilots, but a failure to embed these in mainstream services; and low uptake of technology. This scenario describes a system which tries to meet basic social expectations by providing a bare minimum, albeit with some aspiration to higher quality and more responsive rights-based services. Despite a stated commitment to longer-term change, action is limited and sporadic, with the commitment more rhetoric than reality. Under this scenario, costs increase at a rate of 2% per year, leading to a doubling of adult social care costs within two decades.*

**Solid progress:** *while the stated aims of policy remain similar, there is a more concerted effort to improve outcomes and deliver savings through integration; a greater understanding/embedding of the principles of personalisation; a genuine and sustained attempt to rebalance mainstream services towards a more preventative/rehabilitative approach (i.e. to move away from a 'firefighting' approach which focuses on meeting the needs of people in crisis, to one which can increase investment in prevention and rehabilitation to help people remain living independently at home, or to return home after a spell in hospital if they have experienced some sort of crisis in their health); a sustained commitment to a commissioning-led system; greater support for carers; significant workforce reform; and more innovative use of IT. In practice, the intended benefits are not fully realized to quite the extent envisaged (for example, integration does not deliver as much as expected, and the impact of personalisation is reduced by professional and cultural barriers). Over time, thinking retreats to meeting basic needs, extending some rights and trying to boost prevention/rehabilitation. Under this scenario, costs are contained at current levels.*

**Fully engaged:** *there is a sustained commitment to genuine change, motivated by a desire to realize in full the benefits for the health and social care system and for wider society. Where the evidence base is currently contested or unclear, the mechanisms used surpass expectations and start to really deliver. Thus, partnerships achieve the outcomes/savings that intuition suggests they ought; commissioning proves an effective lever for reforming the system; personalisation is experienced as a lived reality by front-line staff and service users; there are high rates of technology take-up; and there is effective and ongoing workforce reform. This approach is underpinned by a genuine commitment to a rights-based approach, to mainstreaming prevention and rehabilitation, and to using social care funding to achieve a much broader range of social and economic benefits for users and carers. Under this scenario, there is a 2% reduction in costs (albeit the assumptions about what may be possible to achieve verge on the heroic).*