CIPFA

The Road to Reform

COVID-19 as a Catalyst for Change in Funding Social Care

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Executive summary

The need to reform adult social care funding is decades overdue – and remains one of the thorniest issues on the UK political landscape. The sector entered the COVID-19 pandemic on the back foot, facing mounting levels of demand and unmet need, workforce shortages, an increasingly fragile provider market and tightening budgets.

COVID-19 has clearly highlighted weaknesses in the sector's resilience – and should act as a catalyst for reform. The shift in public perception of health and care services means there may never be a better time to address the relationship between state and individual, and to consider what a reformed funding system for adult social care may look like.

Here we discuss the issues and challenges involved in reforming social care funding and consider some of the proposals that have been put forward. We make no recommendations on a given level of spending, nor a particular system for organising the split between state/individual contributions, as these are political decisions. However, we do propose a five-point plan to inform the development of a sustainable and equitable system of funding to ensure the future of this vital sector.

This report was updated in December 2021 to clarify the cost to government of increasing demand for social care; see page 7.

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Acronyms and abbreviations

ADASS: Association of Directors of Adult Social Services

CHC: Continuing healthcare

DHSC: Department of Health and Social Care

LGA: Local Government Association

MHCLG: Ministry of Housing Communities and Local Government

NHS: National Health Service

NI: National Insurance

Local government and adult social care in the pandemic

Adult social care services are facing additional pressures and costs as a result of COVID-19, such as staffing and sickness costs, PPE and deep cleaning, to name but a few. While demand for some services has increased and will continue to do so in the aftermath of the crisis, some providers have experienced loss of income due to under-occupancy and the tragic high death rates in this sector.

More widely, local government is facing extreme financial difficulties as a result of COVID-19. As well as the direct costs of providing vital services during the outbreak, they are facing huge income losses from business rates, council tax, fees and charges. This presents not only a cash flow problem, but has implications for their overall budget, medium-term financial plans, service transformation and savings plans.

Many of the additional costs faced by councils relate to social care, but other essential local government services have also been called upon to respond to the pandemic, including public health, shielding the vulnerable, homelessness services and children's services. While there have been reliefs from the UK Government and additional funding of £3.7bn to date, this must cover the additional costs of COVID-19 across **all** council services, not just those associated with social care – so this must stretch a long way.[1]

Despite this, councils have recognised the need to support the fragile social care provider market as outlined in guidance from LGA and ADASS,[2] and taken action to support providers. Councils are also administering the £600m Infection Control Fund[3] for social care providers (from which they do not benefit), pushing the onus onto councils to support the social care provider market as a whole rather than central government directing support for this sector as they have for other areas of business.

The most recent data collected by MHCLG from local authorities on the financial impact of COVID-19 suggests that for the financial year 2020/21 total income lost will amount to £6.5bn and total additional expenditure will be £4.4bn, of which around £1.8bn directly relates to adult social care.[4]

However, a report commissioned by the LGA and ADASS suggested that social care providers could face over £6.6bn in extra costs due to COVID-19 by the end of September, and that £3.3bn of this could fall on local authorities.[5] The ADASS Annual Budget Report 2020 found that only 4% of adult social services directors are confident their budgets are sufficient to meet statutory duties – a decrease from 35% for 2019.[6]

What is clear is that adult social care was ill-prepared for responding to such a crisis. A decade of austerity, increasing demand, lack of investment and workforce issues all meant that the sector was on the back foot on entering the pandemic. These issues are explored further in our work with the Institute for Government.[7]

While the full cost impact of COVID-19 is as yet unknown, it is widely expected that the true costs will greatly outstrip the funding provided to date. Councils are acting on trust that the additional costs incurred, including those related to social care, will be met by the government, but there have been mixed messages on this to date.

COVID-19 – a catalyst for change

COVID-19 has clearly highlighted weaknesses in the social care sector's resilience – and should act as a catalyst for reform. The shift in public perception of health and care services means there may never be a better time to address the relationship between state and individual, and to consider what a reformed funding system for adult social care may look like.

Given the tightening of local government funding in recent years, and the fact that social service budgets are already widely over-stretched,[8] it is essential that:

- Sufficient funding is provided to cover additional costs of social care and wider council services as a result of COVID-19.
- The weaknesses revealed in the social care sector's resilience should act as a catalyst to drive the long-awaited reform of social care funding.
- Until a long-term solution to the issue of social care funding can be implemented, adequate funding is provided to put the sector on a financially sustainable footing and enable it to withstand any future shocks.
- Such reform should be strategically informed, financially sustainable, equitable and underpinned by a clear understanding of the challenges of funding social care.

Challenges of funding adult social care

In order to develop a strategic and sustainable solution, it is critical to understand the challenges of funding adult social care. Given the many years in which action has been restricted to short-term fixes, such solutions are now more important than ever and should lead to long term, strategically informed, financially sustainable and equitable change. It is also crucial that reforms recognise the interdependence of spending on health, public health, adults and children's social services.

We have identified some key challenges that we believe have made it difficult to respond appropriately to social care needs, and which would need to be addressed when considering future funding.

Individuals face the possibility of catastrophic care costs

Many remain unaware that social care is not, like the NHS, free at point of care, but rather is means-tested. Publicly funded care is available only to those with care needs above a defined level and who fall within the parameters of the means test.

For residential care the parameters are set by the DHSC (with limited discretion for councils, eg around disregarding the value of the home).[9]

- Those with assets above the upper capital limit (£23,250) are liable for the full cost of care, until they reach the upper limit.
- Those between the upper and lower limit must contribute to the cost of care.
- Those below the lower limit (£14,250) will receive publicly funded care.

It is worth noting that the capital limits have been frozen at their current levels since 2010/11.

As property assets are included in the means test, many people face the prospect of having to sell their home to pay for care. Since 2015 however, deferred payment agreements have been possible, where an individual does not have to sell their home to pay for care within their lifetime.[10]

For non-residential care, councils can decide whether to charge for care, and must have a charging policy to determine access to funding towards costs of care. [11] The means test must be at least as generous as that set for residential care.[12]

The issue of social care funding clearly needs to be addressed at a whole population level, but this alone is not enough. While many people will require no social care at all, at the other end of the spectrum a small number of individuals will incur huge care costs. As many people self-fund the cost of their care, those who have significant care needs can potentially face 'catastrophic care costs'. In 2011, the Dilnot Commission found the median cost of care to be £20,000, but some could incur costs of £250,000.[13] More recently, Age UK suggested that in 2018/19, some 5,190 people were classed as self-funders with depleted funds, meaning that they had run down their assets as a result of paying care costs. This represents an increase of more than 37% on the previous year.[14]

It is a matter of chance whether long-term care needs are classed as health or social care. For example, care for an individual with cancer would be funded by the NHS via Continuing Healthcare (CHC),[15] but that for an individual with Alzheimer's is subject to a means test. As you can see from this example, the differential is too sharp. This means that the decision on eligibility for CHC is cost-critical, both for organisations and individuals, causing unnecessary disputes.

All this suggests that social care needs to follow a pattern for which risks should be pooled – as for the NHS or fire insurance.

Managing increasing demand

An ageing population which is living longer and has increasing levels of care needs means that there is increasing demand for adult social care services. However, since 2015/16 the greatest increase in requests for support have come from the working-age population.[16]

It is also widely accepted that there is unmet need, although this is difficult to quantify. This is partly due to means testing criteria (those excluded from public funding due to their level of need not meeting the threshold) and partly due to those who do not realise they are eligible or who don't come forward. This is not just a moral issue, but also relates to effectiveness – providing for lower level needs earlier may prevent deteriorating health and avoid pressures on those providing informal/unpaid care.

In recent years, local authorities have developed several strategies to assist them in managing demand,[17] including:

- Tightening eligibility criteria.
- Helping people to maximise their independence.
- Reducing use of residential care and increasing support in the community (such as extra care housing, etc).
- Use of community-based support, and/or use of asset-based assessments to help link with community organisations.
- Improving decision making on appropriate levels of care.
- Developing models of care where providers are expected to deliver agreed outcomes.
- Use of personal budgets to assist individuals in finding their own solutions.
- Offering improved support for carers and use of volunteers.

Such measures have been used successfully to some degree to reduce demand (or costs) and improve outcomes and have doubtlessly helped many councils to survive austerity. It has been suggested that around 20-25% of all savings in adult social care between 2010 and 2015 were from managing demand.[18]

Public funding has not kept pace with demographic demands

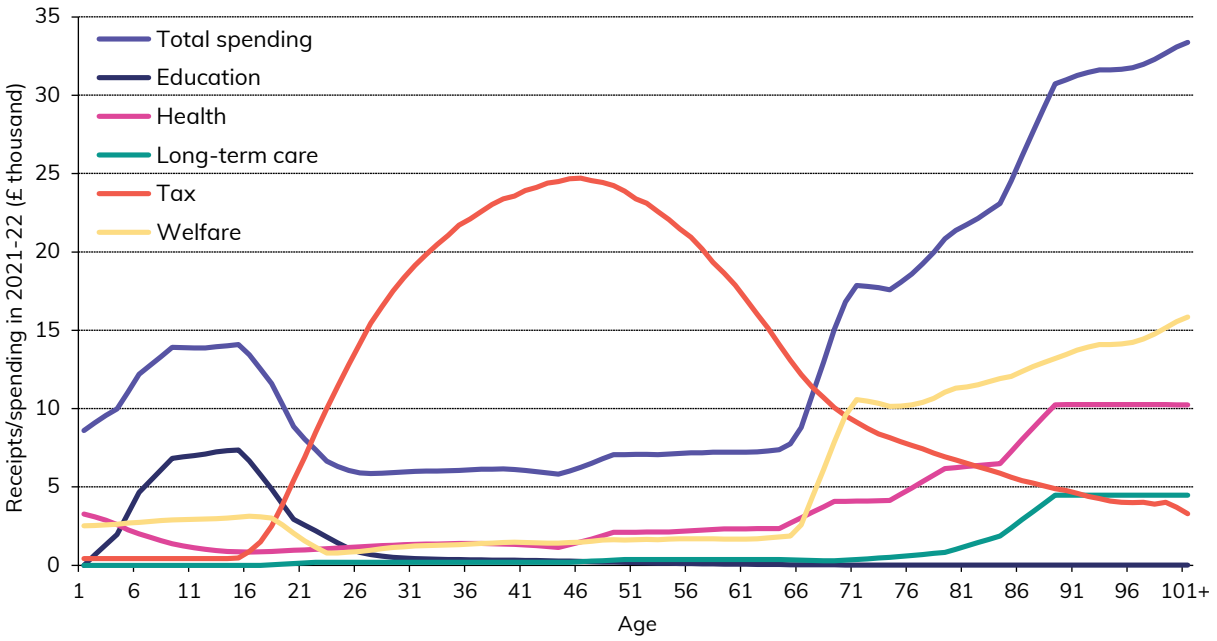
Real terms funding has not kept pace with demographic demand. While demand management and efficiency measures are an important part of the picture, and have enabled councils to keep services going, they will not solve the problem entirely.

Successive governments have recognised this and provided additional funding on an ad hoc basis – notably via the Better Care Fund, improved Better Care Fund, council tax precept and social care support grant. However, these short-term measures are papering over the cracks and do not enable long-term, sustainable financial planning.

Our work with the Institute for Government on Performance Tracker 2019,[19] (pre-dating COVID-19) showed that if there is no change to the means and needs-tested eligibility system, demand for publicly funded adult social care will increase by around 11% by 2023/24. This means that the government would need to spend £20bn to continue to provide the same scope and quality of care. This is faster than spending on adult social care has risen in recent years, and faster that local government spending power is expected to grow by 2023/24.

What is needed is a long-term view to enable planning to be more sustainable and sensibly tied to real demographic pressures. While this sounds challenging, society has already absorbed the cost of a 25% increase in the over 85's population between 2009 and 2019,[20] and long-term social care is only a proportion of the non-pension spend, as illustrated by the projections shown below.

Representative profiles for tax, public services, and welfare spending, 2021 to 2022, UK



Source: Office for Budget Responsibility, Fiscal sustainability report, January 2017

Some reallocation of resources would make sense, particularly when you consider that the largest areas of spend on those of retirement age – pensions, acute care and benefits – do not contribute to reducing the long-term demand for social care in the way that other spending might. So, while additional spending on social care will be needed, to a certain extent this may be a matter of making choices within the existing spending envelope.

The right long-term preventative investments are not being made

Investment decisions are critical. When budgets are tight, there is intense pressure to meet immediate need, but this approach squeezes out the preventative investment which would enable a more secure footing to be reached in the longer term. Rather it accelerates the next crisis, which in turn requires a short-term fix.

We need to change the mindset around preventative investment. It is not only about public health, but also applies across the public services and can both improve outcomes and yield benefits such as avoidance of future costs, reduced demand for services and improved financial sustainability. We need to look at investment beyond the political cycle and measure the extent of preventative investment being made in social care, and the future revenue obligations which will accumulate if such investment is not made.

CIPFA and PHE have developed a framework to improve the evaluation of preventative investments, which can be applied across multiple organisations and is applicable to all public services.[21]

Provider problems

Most social care services (not only residential care) are commissioned by local authorities, but provided by private companies, and this market has been experiencing trouble for some time which has only been exacerbated by COVID-19.

Spending on adult social care has increased since the low of 2014/15 (but remains below 2010/11 levels in real terms),[22] and much of this goes to the provider market. While local authorities have tried to limit how much they pay for services, providers have been hit by increasing costs (particularly for staff as a result of National Living Wage).

In the early years of austerity, local authorities tried to control costs by holding down the fees they paid to providers. Between 2009/10 and 2013/14 spend on residential and home care costs was cut by 8.6% and 5.3%, respectively, in real terms.[23] Self-funders typically pay more for their care than those in receipt of publicly funded care, as providers tend to 'cross-subsidise'. However, an increasing number of care providers are going out of business or handing back contracts. Some are now focusing on services for self-funders and separating self-pay homes from those providing for publicly funded care.[24] All of this can lead to supply problems and risks a lack of investment in services focused on publicly funded care.

The experience of COVID-19 has exacerbated the situation in the provider market. Providers of both home care and residential care have faced increased costs in relation to staffing and sickness costs, PPE and deep cleaning. While the £600m Infection Control Fund has covered some of these costs, the purposes for which it can be used are restricted.[25] Some providers have also experienced loss of income as a result of high death rates and under-occupancy, as those awaiting care are reticent to take up services during the outbreak.

The market, unaided, cannot provide what is needed

Nowhere in the world does the private sector provide an insurance product for social care. This is not because they are unwilling, but because they cannot predict the cost curve for the current market of insurance purchasers. Costs could well be decades into the future and further shifts in patterns of spending could occur during that time. The private sector cannot take the risk of such 'aggregate shocks', so there is a complete market failure.

The key difference in public funding of social care is that the state can change the level of future funding in response to an aggregate shock, as the private sector could not. Under the current system people are forced to self-insure to a certain extent, leading to strong incentives to gaming such as gifting assets. The Care Act proposals would have addressed this to a certain extent and reduced the CHC boundary issue.

Reform of social care – the road to nowhere?

Reform of adult social care has been on the agenda for decades, and the timeline of reform to date has been a long and bumpy road. Details of some of the major milestones over the last 20 years are set out in the **annex**.

Between 1997 and 2017 there were: four major independent reviews/commissions, four Green Papers/ major consultations, three White Papers and three Acts that made provisions for reform. Despite all of this effort, there have been no major changes to funding for adult social care. During this time there have also been numerous reports by parliamentary committees and other bodies making the case for urgent reform.

In June 2017 the government committed to bringing forward a Green Paper to address reform of adult social care funding. Three years later, proposals are still awaited. In the absence of reform, successive governments have sought to address the social care crisis via short-term injections of funding on an ad hoc basis.

Whilst there is no shortage of policy proposals and models for reform, what is missing is political consensus and decisions on a way forward.

Proposals for funding reform

Many of the proposals put forward for reform of adult social care funding involve making the means test more generous, such as those proposed (but not yet implemented) in the Care Act 2014.[26] This would increase the number of people eligible for publicly funded care relative to self-funders.

Such measures would incur an additional cost to the public purse, so would likely need to be accompanied by a revenue raising mechanism or commitment to additional funding.

Under the current system, self-funders typically pay more for their care; if there is no change in the rates paid, and a significant number of self-funders become eligible for public funding, then providers could see a sudden drop in their income, particularly in those areas where there are a high number of self-funders.

The following considers some of the most common proposals for reforming adult social care funding.

Overview of proposals for funding reform

Raising capital limits

How does it work?
Adjusts the parameters of the current means test – the upper and/or lower capital limits.

Revenue raising?
No – raising the capital limits would cost more, as more people would be eligible for public funding.

Risk pooling?
Not for anyone with assets above the upper limit, who still bear risk for the cost of their care. Only once they have depleted their assets to the level of the upper limit will they become eligible for public funding.

Equitable?
Protects the same level of assets (the lower limit) for everyone. The risk remains that this could encourage people to 'spend down' in order to meet the eligibility threshold for public funding.

It is clear?
Even though this is the current system of means-testing, it is complex and generally poorly understood.

Capping care costs

How does it work?
People pay for their care up to a defined lifetime cap, then public funding takes over. This could be coupled with a corresponding floor, below which assets are exempt.

Revenue raising?
No – introducing a cap would require more public funding (dependent on level it is set at) and would require monitoring of costs and care needs.

Risk pooling?
Pools the risk of catastrophic care costs, but only amongst those exceeding the cap.

Equitable?
Intended to protect against catastrophic care costs, but the impact would depend on the level of the cap. A low cap would protect more people, but at greater cost to the public purse. A higher cap may benefit only wealthy individuals.

It is clear?
Lifetime cap is complex and difficult to explain – especially when paired with a floor.

General taxation

How does it work?
Funds collected from taxation are allocated (or ring-fenced) specifically for social care.

Revenue raising?
Yes – over both the short and longer term. Could involve ring-fencing a proportion of a specific tax or increasing taxes and allocating this to social care. Would need to be flexible and regularly adjusted if it were to adapt to changing levels of need.

Risk pooling?
Costs and risks of catastrophic costs would be spread across society, similar to current arrangements for health costs via the NHS.

Equitable?
Fairness and burden would be determined by the detail of how this would operate in practice.

It is clear?
General taxation to pay for public services is well understood.

Inheritance tax increase

How does it work?
Inheritance tax would be increased with a proportion allocated to social care.

Revenue raising?
Potential to raise revenue, but the amount of tax collected would be dependent on the property market, and so would be difficult to forecast. To keep pace with demand, the increase would likely need to be substantial.

Risk pooling?
As this is a national tax, it does involve an element of risk pooling. However, given the potentially low levels of revenue and risk of volatility, this would have only limited ability to protect from catastrophic costs.

Equitable?
Unlikely to be perceived as fair, especially where it involves housing assets. While inheritance tax targets those with asset wealth, it carries the risk of being avoidable via tax planning.

It is clear?
As this involves adjusting an existing tax, it is likely to be well understood.

Local taxation increase

How does it work?
Most likely via increasing council tax or precepts.

Revenue raising?
Additional revenues raised locally, allowing funding to be allocated according to local need. Unlikely to raise sufficient revenues to keep pace with growing demand.

Risk pooling?
Dependent on mechanism of distribution. Revenues raised unlikely to be sufficient to adequately protect against catastrophic costs.

Equitable?
Local property taxes depend on regional wealth – so could exacerbate inequalities.

It is clear?
Likely to be well understood as operates in same way as existing local taxation.

National Insurance (NI) extension

How does it work?
Extend NI to include contributions from those over state pension age.

Revenue raising?
Yes – over both the short and longer term, but unlikely to be sufficient to keep pace with growing demand.

Risk pooling?
Risk is pooled by redistributing costs across society as NI is a national tax. Revenues raised unlikely to be sufficient to adequately protect against catastrophic costs.

Equitable?
NI is levied on income, so risks those with the highest levels of wealth being less likely to pay. Majority of burden would remain on working-age earners.

It is clear?
Easily understood as operates in same way as existing NI contributions.

Mandatory social insurance

How does it work?
Individuals pay into insurance fund ring-fenced for social care, likely by automatic deduction from earnings/pensions.

Revenue raising?
Yes – in both long and short term. Revenues raised would depend on the level and extent of requirement to contribute. Establishing and administering the system would involve some cost.

Risk pooling?
Pools risk across society if contributions are made by majority of the population. Has the potential to adequately protect against catastrophic costs.

Equitable?
Generally perceived as fair if contributions set proportionate to income, but potential for those with high wealth and low income to contribute less. Some proposals involve contributions from only those over 40.

It is clear?
No precedent in the UK, so may not be as well understood as in other countries. Highly transparent system, as individuals aware of how much they contribute.

Voluntary insurance (pooled fund)

How does it work?
Contributions are automatically deducted from wages and collated into a pooled fund. Individuals have the choice to opt out of the scheme.

Revenue raising?
Would enable revenue to be raised in short term as current earners would help fund care for the elderly population, but would take time to raise funds to meet demand. Sustainability would depend on the extent to which people opt out.

Risk pooling?
Pools risk but only for those who remain opted in. Risk that the system would be unsustainable if too many opted out.

Equitable?
Alongside other direct deductions from earnings, such as auto-enrolment pensions, there is a risk that contributions become too great a burden, potentially encouraging opt out from both. Also risks becoming unsustainable if those on high incomes opt out and find alternative means of funding their care. Unclear what, if any, protection would be in place for those who do not contribute – and the impact this may have on opt out rates.

It is clear?
Potential for comparison to pension scheme. Unlike the pension scheme this runs the risk of seeing no return at all, should there be no need for care.

Voluntary pension scheme (individual fund)

How does it work?
Contributions automatically deducted from earnings and held in an individual fund. Individuals would have the option to opt out. Like auto-enrolment workplace pensions, but unclear whether fund could be ring-fenced for social care.

Revenue raising?
No immediate revenue raised. Long term sustainability depends on how much people can save before the need for social care arises. Value of individual funds would be subject to market changes.

Risk pooling?
No, risk remains with the individual. Unlikely that most individual funds would be sufficient to bear the brunt of catastrophic costs.

Equitable?
Alongside other direct deductions from earnings, such as auto-enrolment pensions, there is a risk that contributions become too great a burden, potentially encouraging opt out from both. Value of individual fund is proportionate to earnings, so likely to be perceived as unfair. Unclear what, if any, protection would be in place for those who do not contribute.

It is clear?
Modelled on existing pension schemes, so likely to be some understanding, but would depend on detail of operation.

Five-point plan for a sustainable and equitable system

There is a critical need to improve the long-term financial sustainability of the social care system. This can be achieved either by adjusting levels of funding or adjusting service expectations. This is a political and economic choice – but if neither option is taken, an unsustainable position will result. If there is to be no reduction in services, then sustainability requires enough headroom for investment in preventative measures, on a secure enough basis to facilitate long-term planning.

Although a separate policy matter, it is worth noting the importance of changes to local government financing arrangements. The movement towards incentivising local revenue raising via property taxes ignores the issue of relative need. Unless this is adjusted adequately, the overall sustainability of social care could be fatally undermined.

After decades of failing to reform adult social care, the experience of COVID-19 should act as a catalyst for change. The reform of social care funding should be strategically informed, financially sustainable, equitable and underpinned by a clear understanding of the challenges of funding social care.

While we make no recommendations on a given level of spending, nor a specific system for organising the split between state/individual contributions, we propose the following five-point plan for the development of a sustainable system:

1. A mechanism must be found to provide more stable and adequate long-term planning for social care spending within the context of the whole health and care system.
2. Wider spending on supporting people should be reconsidered from a zero-based perspective, with an expectation that some rebalancing from other spending programmes will likely be appropriate (eg pensions, acute care and welfare).
3. Preventative investments should be encouraged/enabled to maximise long-term sustainability and value for money. This could be achieved by directed funding, incentives and/or reporting requirements.
4. The system needs to ensure fairness within/between generations and to protect individuals from catastrophic costs by pooling risks.
5. Reduce the sharpness of the differential between social care as a largely paid for service and health as an essentially free-at-point-of-use service.

Annex – 20 years of failing to reform

This is not intended to be exhaustive, but rather illustrates some of the milestones along the road to reform.

March 1999 **Royal Commission on Long-term Care (Sutherland Commission) – With Respect to Old Age: Long Term Care – Rights and Responsibilities.** Recommended free personal care funded by general taxation and a more generous means-test of £60,000 (in 1999 prices).

July 2000 **The NHS Plan: The Government's response to the Royal Commission on Long Term Care.** Rejected proposal for free personal care and made only minor changes to the means-test in line with inflation. Accepted a number of other proposals on free NHS nursing care for care home residents and three month disregard of value of home for those in care homes.[27]

March 2005 **Labour Government's Green Paper – Independence, Well-being and Choice** aimed to set the social care agenda for the next 10-15 years. While this was wide ranging, it proposed no real reform of entitlement to state-funded care.

April 2006 **Labour Government White Paper – Our health, our care, our say: a new direction for community services** was built on the 2005 Green Paper, but included no specific funding proposals.

March 2006 **Securing Good Care for older People: Taking a Long-term View (Wanless Social Care Report)**. This independent report proposed widening eligibility through a 'partnership' model of funding, where everyone is entitled to some level of free care but should contribute to the cost of care based on their income.

July 2009 **Labour Government Green Paper – Shaping the Future of Care Together** proposed a 'National Care Service' with universal access to free care and proposed three options for funding: partnership, insurance and comprehensive (state insurance) models.

March 2010 **Labour Government White Paper – Building the National Care Service** confirmed universal access to free personal care at home from 2011, a cap on paying for residential care from 2014, and free-at-the-point-of-use social care for all after 2015.[28] Proposed to fund via the comprehensive option, in which 'need and not means' would determine eligibility. This would require everyone to contribute via a 'fair care contribution'. This was labelled a 'death tax' by the Conservatives in the subsequent general election, thus ending cross-party talks.

April 2010 **Personal Care at Home Act 2010** received Royal Assent. This provided the legislative basis for free personal care for those with the highest need, but the Act was never implemented as Labour lost the subsequent election.

May 2010 **The Coalition – our Programme for Government**. The Coalition government says it understands the urgency of reform and commits to establish an independent commission to review options for social care, including voluntary insurance and partnership models.

July 2011 **Dilnot Commission – Fairer Funding for All**. Recommended a partnership model with a more generous means test and a lifetime cap of between £25,000 to £50,000 (depending on age and need) on social care costs.

March 2012 **Health and Social Care Act 2012**. This introduced major changes for the NHS, but little in relation to social care.

July 2012 **Caring for our future: progress report on funding reform**. The government's White Paper supported the principles of the Dilnot capped cost model but did not accept the proposed levels or the immediate introduction of funding reform, stating that "given the size of the structural deficit and the economic situation we face, we are unable to commit to introducing the new system at this stage". A timetable was set out for further consideration of the capped cost model and the extended means test threshold, with decisions to be made at the 2013 Spending Review.

February 2013 **Health Secretary announced parameters of funding reforms** for implementation in April 2017, including cap to be set at £75,000 and a more generous means-test with an upper limit set at £123,000 where the value of the home is included.

March 2013 **Budget 2013** announced changes to the proposed social care funding reforms. A reduction on the cap from £75,000 to £72,000 and a reduction in the upper limit of the means test from £123,000 to £118,000, with implementation brought forward by a year, to April 2016.

July 2013 **Caring for our future: Consultation on reforming what and how people pay for their care and support** was launched by the Department of Health. This proposed an upper limit of around £27,000 for those where value of home is excluded from the means-test from April 2016; lower limit of means test to increase to around £17,000 (from £14,250) from April 2016 and standard contribution to living costs of £12,000 for care home resident with capital less that relevant upper limit. It also recognised that it would not be fair on working age adults, less able to plan and prepare for future care costs, to face the same care cap as older people, and committed that those below state pension age will have a lower cap from April 2016.

May 2014 **Care Act 2014** passed, introducing wide ranging reforms of social care organisation and delivery. It included proposals for the introduction of more generous means-test and cap as before, to be implemented in April 2016.

September 2014 Commission on the Future of Health and Social Care in England (Barker Commission) – **A New Settlement for Health and Social Care.** Independent Commission established by The Kings Fund to explore what a new settlement for health and social care might involve. Recommended a new settlement based on a single integrated budget for health and social care, to be funded through taxation and changes to existing public services.

February 2015 **The Care Act 2014: Consultation on draft regulations and guidance to implement the cap on care costs and policy proposals for a new appeals system for care and support**. Regardless of the previous recognition of the need for a lower cap for working age adults, this proposed a lifetime zero cap for those turning 18 with eligible care and support needs or developing eligible needs up to the age of 25, and a cap of £72,000 for people of all other ages. It explained that the tiered approach had been abandoned due to funding constraints.

April 2015 **number of social care reforms implemented**, including universal deferred payment arrangements, new support for carers and a national level of care and support needs to make care and support more consistent across the country.

July 2015 **Government postpones reforms on paying for care**. It was announced that commitment to the cap on care costs and other Phase 2 reforms in the Care Act 2014 remains, but implementation was to be delayed from April 2016 to April 2020. There was also no change to the upper and lower limits of the capital means test – last revised in **March 2010**.

March 2017 **Spring Budget 2017**. The government commits to set out proposals in a Green Paper to "put the social care system on a more secure and sustainable long-term footing".

June 2017 **Queen's Speech.** The minority Conservative Government commits again to produce a Green Paper to set out options to put social care system on a more secure financial footing.

November 2017 **Green Paper delayed** until July 2018 and stated the intention to focus on care for older people.

December 2017 **Government announce cap on care costs will not be introduced in April 2020** (previously deferred from April 2016), but do not set a new implementation date.

2018-2019 Repeated delays to Green Paper. In January 2018, **lead responsibility** for the Green Paper transferred to DHSC. In March 2018 the government set out **seven principles** to guide thinking on the Green Paper. In October 2018 the government committed to a **single Green Paper on social care for all adults**.

July 2019 **New PM** commits to '*fix the crisis in social care once and for all with a clear plan*', without reference to the nature or timescale. There is speculation that the Green Paper has been dropped in favour of a White Paper – but no confirmation.

March 2020 **Secretary of State writes to all MPs and peers** inviting them to share views on "how to secure a long-term, sustainable solution to ensure the reforms will last long into the future" ahead of "structured talks on reform options" in May.

Endnotes

[1] MHCLG, **Comprehensive new funding package for councils to help address coronavirus pressures and cover lost income during the pandemic**, 2 July 2020. £3.7bn Includes two tranches of £1.6bn and a further £500m. This does not include the £600m Infection Control Fund, as this funding was channelled through local authorities to social care providers. It should be noted that figures quoted apply to England, as social care is a devolved matter, the devolved nations of Scotland, Wales and Northern Ireland have put in place their own arrangements to support social care.

[2] LGA, ADASS, CPA, **Social care provider resilience during COVID-19: guidance to commissioners**, 13 March 2020 and LGA/ADASS, Temporary funding for adult social care providers during the COVID-19 crisis, 8 April 2020.

[3] DHSC, **Adult social care infection control fund ring-fenced grant 2020 – Local Authority circular**, 22 May 2020.

[4] MHCLG, **Local authority COVID-19 financial impact monitoring information – Round 3**, July 2020.

[5] LGA, **Social care providers face more than £6bn in extra COVID-19 costs,** June 2020.

[6] ADASS. **ADASS Budget Survey 2020 Part #2 Impact of COVID-19 on budgets**, June 2020.

[7] CIPFA and Institute for Government, **How fit were public services for coronavirus**, August 2020.

[8] ADASS, **Budget Survey 2020**, June 2020 shows adult social care made up around 37% of council budgets in 2016/17, 2017/18 and 2018/19 (excluding schools budgets)up from 34% in 2010/11.

[9] Figures shown apply to England only. Social care is devolved, so the devolved nations have different means tests in place. For residential care the capital thresholds for residential are as follows: Wales has only an upper limit of £50,000; Scotland has lower limit of £17,500 and upper limit of £28,0000. In Northern Ireland, limits are as for England.

[10] This means an individual does not have to sell their home to pay for care during their lifetime, but receive funding from their local authority, who then recover the cost from the sale of their home (eg after their death). DHSC, **Care and support statutory guidance**, March 2020.

[11] DHSC, **Care and support statutory guidance**, March 2020.

[12] Again, for non-residential care there are differences across the devolved nations. In Wales non-residential care costs are capped at £90 per week. Scotland provides free personal and nursing care. Northern Ireland provides free domiciliary care.

[13] Commission on Funding of Care and Support (Dilnot Commission), **Fairer Funding for All**, July 2011.

[14] Age UK, **A year on from the PM's pledge that no one would have to sell their home – 14 people are wiped out financially by care bills each day**, July 2020.

[15] NHS, **Continuing Health Care** (CHC).

[16] CIPFA and Institute for Government, **Performance Tracker 2019**, November 2019.

[17] Institute for Public Care, **Surviving the Pandemic: New challenges for adult social care and the social care market**, Prof John Bolton, May 2020.

[18] Institute of Public Care, **What are the opportunities and threats for further savings in adult social care?** 2016.

[19] CIPFA and Institute for Government, **Performance Tracker 2019**, November 2019.

[20] Office for National Statistics, **Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2019**, June 2020.

[21] CIPFA and Public Health England, **Evaluating preventative investments in public health in England**, May 2019.

[22] CIPFA and Institute for Government, **Performance Tracker 2019**, November 2019.

[23] CIPFA and Institute for Government, **Performance Tracker 2019**, November 2019.

[24] House of Commons Library, **Social care: care home market – structure, issues, and cross-subsidisation (England)**, 2018.

[25] DHSC, **Adult social care infection control fund ring-fenced grant 2020 – Local Authority circular**, 22 May 2020 – sets out the conditions of the grant funding.

[26] **Care Act 2014.**

[27] In January 2001, the then Scottish Executive accepted the proposals for free personal care for the over 65's and legislated for this in the Community Health and Care (Scotland) Act 2002, which came into force in July 2002.

[28] Although care would be free at point of use after 2015, there would still be the requirement to pay accommodation costs for residential care where they are able (including a universal deferred payment system to avoid people having to sell their home to pay for care during their lifetime).

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