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Evidence call: **Health and Social Care Committee inquiry into cost of inaction on adult social care reform**

This response is provided by Professor Matt Bennett (**University of Birmingham** and **ESRC Centre for Care**) and Professor Jon Glasby (**University of Birmingham** and Director of **IMPACT – the UK centre for implementing evidece in adult social care**). It highlights the long-standing reform imperative in relation to adult social care (ASC) organisation and funding and economic contributions of adult social care, evidenced in work[1][2] undertaken by Jon Glasby and Matt Bennett.

We briefly address 3 questions set out in the the Health and Social Care Committee's call for evidence, based on our team's wider knowledge base.

1. **What is the cost of inaction to individuals and how might people's lives change with action on adult social care reform?**
2. **Where in the system is the cost of inaction on adult social care reform being borne the most?**
3. **What contribution does adult social care make to the economy and HM Treasury and how might this change with action on reform?**

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

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.

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.

Glasby et al. (2020) 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.[3] The 2010 work was launched by Gordon Brown and formed the basis of the 2010 White Paper/initial plans for a 'National Care Service'. 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 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.

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[1] Sustainable Care: connecting people and systems (ESRC, award ES/P009255/1)

[2] The Centre for Care is funded by the Economic and Social Research Council (ESRC, award ES/W002302/1), with contributions from the Department of Health and Social Care's National Institute for Health and Care Research (NIHR) and partner universities. The views expressed are those of the author(s) and are not necessarily those of the ESRC, UKRI, NHS or NIHR.

[3] 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.

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: Details of the assumptions for reform scenarios (Glasby et al. 2010; 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 realise 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).*

Table 2: 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

Investing in social care can have benefits for broader partners in terms of NHS bed days and enabling more people to work (reduced social security spending, extra tax and NI etc). Spending on adult social care is a good investment - both in terms of the quality of life we want to have together as a society, but also in terms of the knock-on on other public service budgets.

With need and costs projected to rise significantly, and spending, especially on older people's services, falling dramatically, six key impacts are emerging:

1. Increasing levels of unmet/under-met need and rising levels of 'self-funding'.
2. Quality of care: where people are receiving social care support, there are increasing pressures on quality.
3. Pressures on carers: the growth in unmet need is also reflected in growing pressure on unpaid carers (family members, friends and neighbours who provide unpaid support for people with social care needs).
4. Pressures on the adult social care workforce
5. Pressures on service providers: as the gap between need and funding widens, the provider market – mainly for-profit providers – has faced severe and sustained financial pressures.
6. Pressures on partner agencies: when access to adult social care is significantly reduced, pressure can increase on the NHS (a universal service, free at the point of delivery, and unable to 'say no' to people in need in the way adult social care can).

The economic value of unpaid care in the UK:

Petrillo, M., Zhang, J. and Bennett, M. R. (2024). Valuing Carers 2021/2022: the value of unpaid care in the UK. London: Carers UK.

Zhang, J., Petrillo, M and Bennett, M. R. (2024). Valuing Carers 2022: Scotland. Glasgow: Carers Scotland.

Zhang, J., Petrillo, M. and Bennett, M.R. (2023). Valuing Carers 2021: Northern Ireland. Belfast: Carers Northern Ireland.

Petrillo, M. and Bennett, M.R. (2023). Valuing Carers 2021: England and Wales. London: Carers UK.

Our work highlights the increasing economic value of unpaid care across the four nations of the United Kingdom (UK). Unpaid carers in the UK are providing care worth £184.3 billion a year – an increase of 29.3% since 2011. To put these numbers into perspective, the combined NHS budget across all four nations of the UK was approximately £189 billion - this means that unpaid carers are providing care equivalent to the budget of a second NHS in the UK. This value of unpaid care is also over four times the amount of publicly funded spending on adult social care services. People are providing more hours of unpaid care than ever before, and the contributions made by unpaid carers have increased across all Local Authorities and Councils in the UK. If unpaid carers stopped providing care overnight, the health and social care systems in the UK would collapse.

Table 3: Proportion of unpaid carers and the value of care by hours of care and nation, 2021/22 and 2011

	2021/22* unpaid carers (%)	2011 unpaid carers (%)	Nominal Value 2021/22* (£m)	Nominal Value 2011 (£m)	Real Change 2021/22*- 2011 (%)
England					
19 hrs or less	4.4%	7.2%	16,262	17,386	-21.4%
20-49 hrs	1.8%	1.5%	44,250	21,667	71.6%
50+ hrs	2.7%	2.7%	91,310	58,791	30.5%
Total	8.9%	11.4%	151,822	97,845	30.3%
Wales					
19 hrs or less	4.7%	7.4%	969	1,316	-38.1%
20-49 hrs	2.2%	1.9%	2,852	1,578	51.8%
50+ hrs	3.6%	3.7%	6,944	4,855	20.1%
Total	10.5%	13.0%	10,766	7,749	16.7%
Northern Ireland					
19 hrs or less	5.7%	7.4%	580	610	-18.2%
20-49 hrs	3.0%	2.2%	1,776	836	82.6%
50+ hrs	4.0%	3.6%	3,470	2,073	43.8%
Total	12.8%	13.2%	5,826	3,519	42.3%
Scotland					
19 hrs or less	6.5%	5.4%	2,072	1,443	11.5%
20-49 hrs	2.4%	1.7%	4,744	2,755	33.8%
50+ hrs	2.9%	2.7%	9,109	6,181	14.5%
Total	11.8%	9.8%	15,924	10,379	19.2%

Source: The proportion of unpaid carers and value of care by hours of care in England and Wales was taken from the report, Valuing Carers 2021: England and Wales (Petrillo and Bennett, 2023); the figures for Northern Ireland were taken from the report, Valuing Carers 2021: Northern Ireland (Zhang et al., 2023); and figures for Scotland were taken from the report, Valuing Carers 2022: Scotland (Zhang et al. 2024). Columns 'Value 2021/22' and 'Value 2011' are the nominal values of unpaid carers' contributions (which are not adjusted for inflation). The percentage change in unpaid carers' contributions considers the real unit cost, adjusted for inflation using the Consumer Prices Index including owner occupiers' housing cost (CPIH). Note: * 2022 for Scotland and 2021 for England, Wales and Northern Ireland.

Table 4: Change in the real value of unpaid carers' contribution in the United Kingdom, 2011 and 2021/2022

	Real Value 2021/2022* (£m)	Real Value 2011 (£m)	Real Change 2022/2021-2011 (%)
England and Wales	145,679	112,634	29.3%
Northern Ireland	5,350	3,760	42.3%
Scotland	13,215	11,088	19.2%
Total	164,244	127,482	29.3%

Source: The real value of care in England and Wales was taken from the report, Valuing Carers 2021: England and Wales (Petrillo and Bennett, 2023); the figures for Northern Ireland were taken from the report, Valuing Carers 2021: Northern Ireland (Zhang et al., 2023); and figures for Scotland were taken from the report, Valuing Carers 2022: Scotland (Zhang et al. 2024). Columns 'Value 2022/2021' and 'Value 2011' represent the real value of unpaid carers' contributions (adjusted for inflation).
Note: * 2022 for Scotland and 2021 for England, Wales and Northern Ireland.

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