CIPFA The Chartered Institute of Public Finance & Accountancy

# Commons Select Committees on Health and on Communities and Local Government:

# Long term funding of adult social care inquiry

## A Submission by:

## The Chartered Institute of Public Finance and Accountancy

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the people in public finance

**CIPFA, the Chartered Institute of Public Finance and Accountancy**, is the professional body for people in public finance. CIPFA shows the way in public finance globally, standing up for sound public financial management and good governance around the world as the leading commentator on managing and accounting for public money.

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## 1. Executive Summary

1.1 CIPFA believes it is vital that the committees understand the issues to be tackled, and take those factors into account in making recommendations. It is also critical, given the many years in which action has been restricted to short-term fixes, that those factors lead to a long term, sustainable and strategically informed changes. Such recommendations are best made with a view to the position of adult social care as part of the closely linked total £155bn spending on the NHS (£125bn), public health (£4bn) adult (£18bn) and children's (£8bn) social care.

1.2 In that context, CIPFA sets out the issues it believes should be tackled, and highlights the broad policy goals which should be delivered by the changes made. The key issues to be tackled are:

- that public funding has not kept pace with the demographic demands;
- the right long term investments are not being made to the extent required; and
- individuals face the possibility of very severe financial impact, and the market, unaided, cannot provide what is needed to guard against that.

1.3 Having considered those matters, CIPFA sets out the following five point plan for change:

- Find a mechanism, such as setting a minimum percentage of GDP or tax take to be spent on health and social care, to provide a more stable and adequate means of long term planning for social care spending within the context of the whole health and care system. For example, setting the tax take dedicated to health and social care at 24% rather than the current 22% would enable an extra £14bn to be invested, which is in line with CIPFA's assessment of what the system is likely to need.
- Look broadly across all the spending programmes supporting older people and reconsider them on a 'zero-based' point of view, ie with an expectation that some rebalancing between the various programmes is likely to be appropriate in order to achieve that additional investment.
- Direct funding / introduce incentives / sharpen reporting arrangements in ways which give headroom for and encourage the preventative

actions which will maximise longer term sustainability and Value for Money.

- Protect individuals from the possibility of very high social care costs by finding a means of pooling risks.
- Reduce the sharpness of the differential between social care, as a largely paid-for service, and health as an essentially free service.

## 2. Background and Context

2.1 CIPFA[i] sets out the issues to be tackled with the aim of achieving a long term settlement which is both sustainable and equitable.

2.2 CIPFA considers that the limited scope of the proposed Green Paper is a missed opportunity to consider social care issues as a whole. That would address the comparable financial pressures which fall on services for children and younger adults as well as services for older people, and the inter-dependencies between the three areas of service[ii]. CIPFA's comments however, are restricted to the scope announced.

## 3. Issues to be tackled

3.1 Six key problems have recently made it difficult to respond appropriately to the social care needs of older people:

- Public funding has not kept pace with the demographic demands
- The right long term investments are not being made to the extent required
- Individuals face the possibility of very severe financial impact
- The market, unaided, cannot provide what is needed
- The health and social care systems do not fit together as they should
- The wider determinants of social care need are not sufficiently integrated into planning processes

3.2 An adequate solution to the problems faced in providing social care for older people needs to address each of those issues. Considerable government effort has been applied towards the last two of them. CIPFA believes that the path of STPs and possible migration towards Integrated Care Systems as the place-based way of bringing health and social care together has potential, and time is required to allow those initiatives to take root without further intervention[iii]. The practical scope of those initiatives should naturally extend over time to cover the wider determinants of social care demand – not just community health, but also housing and the welfare system. If that programme succeeds, it will help to address the other problems, but there is more action needed, too.

3.3 In that context, it would be unhelpful to introduce further changes in the developing place-based frameworks. We therefore take the view that the last two issues above are already being tackled appropriately, and concentrate in the following only on the first four issues.

**Public funding has not kept pace with the demographic demands**

3.4 The key driver of costs is the population aged 85 and over. There are now 1.6m people over 85, and that is predicted to double by 2030[iv]. Real terms funding for adult social care has not kept pace[v], and while efficiency measures are an important part of the picture, and have enabled local authorities to keep services going, they will not solve the matter entirely. Successive governments have recognised the problem, and injected additional funding on an *ad hoc* basis (notably the transfer from CCG budgets vs the Better Care Fund, the facilitation of increased council tax for the purpose, and the additional £2bn announced in 2017). What's needed, however, is a long term view to enable planning to be sensibly tied to the demographic pressures. That may sound a challenging requirement, but society has already absorbed a 25-fold increase in the over-85's (from 65,000 in 1901 to 1.6m in 2017), and older people's social care (£8bn) is only a small proportion of the non-pension spend on older people (against £80bn on benefits and £50bn on health).

3.5 It is clear that some reallocation would make good sense, but not evident that we need to spend more on older people in total[vi], the more so given

that the biggest areas of spend – pensions, acute care and attendance allowance – don't contribute to reducing the long term demand for social care in the way that other spending might do. It is, then, apparent that extra investment will be needed in social care, but it can be a matter of making choices within the spend on older people, not spending more in total.

**The right long term investments are not being made to the extent required**

3.6 Investment decisions are also critical. When budgets are tight, there is intense pressure to meet immediate needs, but that squeezes out the preventative investments needed to reach a more secure long term footing. That just accelerates the next crisis requiring a short-term fix. The cuts made to public health budgets illustrate that thinking. We need to facilitate the progressing of business cases which cover repayment periods longer than the political cycle. The key is to measure the extent of preventative investment being made, and the future revenue obligations which will build up if no preventative counter-action occurs[vii]. CIPFA has worked with PHE to develop such a methodology, and will be publishing the results in April 2018.

**Individuals face the possibility of very severe financial impact**

3.7 Although we clearly need to do something about the population as a whole, that isn't enough because, while 20% will turn out to have no social care need, and just £20,000 is the median total cost of social care, a small number of people will incur over £250,000 of cost[viii]. That suggests that social care need follows a pattern for which risks should be pooled, as with the NHS (ill health risks fall similarly) or fire insurance cover.

3.8 The Dilnot Commission's research[ix] showed widespread dissatisfaction with the current position. People feel that this position is unjust for two main reasons:

- It is a matter of chance whether an individual faces long term costs classifiable as a health need or as social care (eg Alzheimer's disease). It might not be unreasonable for health and education to be free and social care chargeable, but the differential is too sharp. Moreover, this

makes the process of deciding whether someone qualifies for Continuing Health Care (CHC) cost-critical for both organisations and individuals. That causes unnecessary disputes, stress and gaming.

- Many people feel that, having saved throughout their lives to purchase a house, they should be able to pass the asset on to their descendants subject only to the universally applicable rules of inheritance tax. However, the housing asset is run down to £23,250 under current rules[x].

**The market, unaided, cannot provide what is needed**

3.9 The private sector doesn't provide an insurance product for social care costs: not because they are unwilling, but because they don't know what the cost curve will be for current insurance purchasers – costs may well be 40 years away, and further big shifts in the patterns of old age spending could occur. The private sector can't take on such a potential for 'aggregate shocks', so there is a complete market failure. This is not to blame the private sector: the difficulties faced may be confirmed by the realisation that the problem is not UK-specific - nowhere in the world is there such a market. The key difference in covering this through the public purse is that the state can change the level of the cap in future in response to any aggregate shock, as a private company could not[xi].

3.10 At present people are forced to 'self-insure' – which leads to strong incentives to 'cheat' by giving away assets. As an illustrative example, the proposals enacted (but not implemented) by the Care Act, 2014, would have addressed this and reduced the CHC boundary problem. The extra cost would, eventually, have been some £2bn per annum. As explained above, that (or an alternative solution) could be afforded by reprioritisation of what is spent on older people[xii].

**Conclusions in the context of sustainability and equity**

3.11 There is a critical need to improve the long term financial sustainability of the health and social care system. That can be achieved either by adjusting funding or by adjusting service expectations. That choice is a political and economic matter, but if neither option is chosen, an

unsustainable position will result. If services are not to be reduced, then sustainability requires enough headroom for investment in preventative measures, on a secure enough basis to facilitate long term planning. One way to assist in that would be to set a minimum percentage of GDP or of tax take to be spent on health and social care[xiii].

3.12 The UK spends 9.8% of GDP on health, as defined internationally, compared with 11% in the broadly comparable France and Germany. Moreover, current plans see the % of GDP on health declining, despite the demographic trends. It would make sense for spend on health and the linked area of social care to reflect both the national wealth and the political decisions around the tax burden affordable from that wealth. That suggests that a percentage of the tax take might be a more rounded measure than percentage of GDP. That would also ensure that health and social care received – as a priority area of spend – a proportion of any new taxes. The current tax take is some £700m, 22% of which is accounted for by the £155bn spending on the NHS (£125bn), public health (£4bn) adult (£18bn) and children's (£8bn) social care. An extra 1% of tax take would be worth £7bn. So, for example, setting funding at 24% of tax take in 2018-19 (£169bn) and setting that as a minimum going forward would both sort the current problems[xiv] and provide a more buoyant and stable position on which to plan for the future. If that buoyancy led to more funds being available than needed in a given year, it would make sense either to set aside funds for future pressures or to invest in additional preventative activity, both of which would increase long term sustainability.

3.13 It is a separate policy matter, but it is also worth noting the importance of the changes to arrangements for local government financing. The movement towards incentivising local raising of money through the council tax and business rates in itself ignores the question of relative needs: unless that is adjusted for adequately, the overall sustainability of social care will be fatally undermined. [xv]

3.14 In terms of equity, the system needs to ensure fairness both within and between generations. That isn't to say that older people shouldn't make a larger contribution overall to the costs they incur than they do currently, given that their wealth relative to younger generations has increased sharply in recent decades, but the balance needs to be rationally

justifiable. The system adopted also needs to protect individuals from very high social care costs by pooling risks.

**Recommendations**

4.1 CIPFA does not recommend any particular level of spending, nor any particular system for organising the split between state and individual contributions to the costs of social care. However, CIPFA believes it is vital to make a strategic change, not to defer a substantive decision, as has already happened several times; and that the solutions reached should:

- Find a mechanism, such as setting a minimum percentage of tax take to be spent on health and social care, to provide a more stable and adequate means of long term planning for social care spending within the context of the whole health and care system.
- Look broadly across all the spending programmes supporting older people and reconsider them on a 'zero-based' point of view, ie with an expectation that some rebalancing between the various programmes is likely to be appropriate.
- Direct funding / introduce incentives / sharpen reporting arrangements in ways which give headroom for and encourage the preventative actions which will maximise longer term sustainability and Value for Money.
- Protect individuals from the possibility of very high social care costs by finding a means of pooling risks.
- Reduce the sharpness of the differential between social care, as a largely paid-for service, and health as an essentially free service.
- Continue to progress STPs and related policy initiatives as the setting for those changes.

[i] This note represents CIPFA's views, as informed by its Health & Social Care Board, made up of financial management practitioners in health and social care. However, there have been many organisations and publications making related points which have fed into this submission: for example, there is much in common

with views expressed by the Dilnot Commission, the Barker Commission, the King's Fund, the Health Foundation, the Nuffield Trust, the Local Government Association, the Association of Directors of Adult Social Services and Public Health England.

[ii] See, for example, the concerns about Children's Services set out in Changing Children's Lives: assessing cost and demand for children's services, 2017 and the results of the ADASS Budget Survey 2017, which reports that 'for the first time, financial pressures due to the increasing care needs of younger adults with disabilities or mental health problems are greater than those due to supporting older people'.

[iii] See the NHS's Local partnerships to improve health and care

[iv] Overview of UK Population, July 2017 – Office for National Statistics

[v] As set out in the ADASS Budget Survey 2017 'total cumulative savings in adult social care since 2010 will amount to over £6bn by the end of March 2018'

[vi] There is a growing view that older people need to contribute more to their care: see for example the comments made by Lord Willets in March 2018

[vii] Duncan Selbie (Chief Executive, Public Health England) outlines the key thinking in his article 'Far better than cure' in the CIPFA Perspectives publication 'Funding a healthy future', 2016

[viii] Pattern as per Dilnot Commission report,2011

[ix] Summary of the Big Care Debate consultation, Department of Health, 2010 and Public Opinion Research on Social Care Funding: A literature review on behalf of the Commission on the Funding of Care and Support, Ipsos MORI Social Research Institute, 2011, as referenced in the Dilnot Commission report, 2011.

[x] 'When people then experience the system, many perceive it to be unfair. This is particularly the case when people have to sell their homes, or use up the majority of any assets they have, to pay for care. The current system does not encourage or reward saving, and is poorly understood. People are not prepared, which often leads to poor outcomes and considerable distress'. Dilnot Commission report, 2011. There is nothing to suggest that views have changed since.

[xi] This was at the core of the Dilnot Commission's arguments

[xii] See the still-relevant 'After the Downturn', 2009 for CIPFA's view of the principles of prioritisation in the current tough financial conditions

[xiii] CIPFA has argued for this consistently for some years, as for example here and in More Medicine Needed: The Health of Health Finances Revisited, 2016. The Barker Commission (2014) recommended that 'the government should plan on the basis that public spending on health and social care will reach between 11 and 12% of GDP by 2025' without recommending a 'golden ratio' as such.

[xiv] These figures are illustrative, but the additional £14bn would be in line with the assessment made in 'More Medicine Needed' (£10bn for the NHS) and by the LGA on adults (£2bn) and children's (£2bn) social care

[xv] See CIPFA's response to the consultation on changes to business rates