

# UNIVERSAL QUALITY SOCIAL CARE

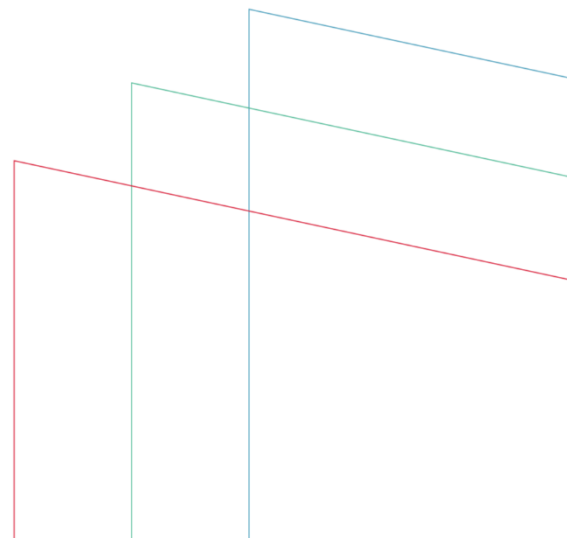
## APPENDIX

This appendix accompanies the report which is available at  
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## APPENDIX

This appendix explains the methods for costing various models of universal social care provision in England, based on needs identified from health and disability data for the entire population aged 18 and above. All calculations and assumptions are explained in detail, using existing literature and official statistics, and wherever relevant, examples from other countries. It provides results from overall costings for the tax year 2021-22 as well as projections over the following ten years in real terms, taking into account projected increase in demand. It also estimates employment creation stemming from the annual investment and potential tax revenue from increased economic activity.

### Who is disabled and to what extent?

The Equality Act 2010 defines a person as disabled if they “have a physical or mental impairment that has a substantial and long-term negative effect on their ability to carry out normal daily activities”<sup>1</sup>. Table 1 uses data from the Families Resources Survey (FRS) on the extent to which a person’s activities are limited by disability to estimate the total numbers who have their activities either “limited a lot”, which we term “severely disabled”, or “limited a little”. Numbers represent those residing in private households in England, and thus potentially in need or receipt of domiciliary care. This split yields similar proportions of those severely and moderately limited in their activities to those found for the UK in EU-SILC.

**Table 1. Disabled people (living in private households) - England**

	18-64	65+	All 18+
Numbers disabled	6,119,000	4,466,000	10,585,000
As % of age group	18%	45%	24%
severely disabled as % of the disabled	41%	47%	43%
severely disabled as % of age group	7%	21%	11%

*Source: Own calculations using FRS microdata (2019/20 wave)*

### Who has care needs?

The Care Act 2014 defines the minimum needs threshold for eligibility to receive means-tested care from Local Authorities who *must provide for needs that meet the following three conditions*:

- *The needs arise from or are related to a physical or mental impairment or illness.*
- *As a result of those needs the adult is unable to achieve two or more of the specified outcomes:*
  - *managing and maintaining nutrition*
  - *maintaining personal hygiene*
  - *managing toilet needs*
  - *being appropriately clothed*
  - *being able to make use of the home safely*
  - *maintaining a habitable home environment*
  - *developing and maintaining family or other personal relationships*
  - *accessing and engaging in work, training, education or volunteering*
  - *making use of necessary facilities or services in the local community, including public transport and recreational facilities or services*
  - *carrying out any caring responsibilities the adult has for a child*

*An adult is to be regarded as being unable to achieve an outcome if they:*

- *are unable to achieve it without assistance*
  - *are able to achieve it without assistance but doing so causes the adult significant pain, distress or anxiety*
  - *are able to achieve it without assistance but doing so endangers or is likely to endanger the health or safety of the adult, or of others*
  - *are able to achieve it without assistance but take significantly longer than would normally be expected.*
- *As a consequence of being unable to achieve these outcomes there is, or there is likely to be, a significant impact on the adult's wellbeing<sup>2</sup>*

The FRS does not include information on met and unmet care needs, but we know from other studies that the need for care cannot be directly inferred from the extent to which activities are limited by disability. For example, the needs of some disabled people may be better met by additional equipment or adaptations to their house. Further, not all care needs are met, even for those who receive some formal and/or informal care.

Like the FRS, the annual Health Survey for England (HSE) asks whether activities are limited a little or a lot, but also includes information on care needs, care received (formally or informally) and on unmet needs, though only for those aged 65 and over. Respondents are specifically asked about difficulties with 13 activities - Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) - which are

similar to the outcomes specified in the Care Act.<sup>12</sup> For each activity listed, the respondent can choose between 4 answers:

1. I can do this without help from anyone
2. I have difficulties doing this but manage on my own
3. I can only do this with help from someone
4. I cannot do this

Following Dunatchik et al.,<sup>3</sup> we take answers 2-4 to mean being “unable to achieve an outcome” under the Care Act definition, and define two levels of overall care needs:

- A more restrictive **“LA” definition of care needs**, closely related to that used by Local Authorities in interpreting the Care Act 2014, which specifies that needs are:
  - as a result of a long-standing illness
  - include two or more ADL/IADLs for which help is needed, and
  - result in low well-being, scoring less than 7 for subjective well-being (SWB) on the HSE’s life satisfaction index, which ranges from 0 to 10.<sup>3</sup>
- A **“wider” definition of care needs**, which specifies that needs are:
  - as a result of a long-standing illness
  - include one or more ADL or 2 or more IADLs or mobility needs

The wider definition therefore includes some with “moderate” needs who do not qualify under the LA needs definition. Table 2 shows the prevalence among those aged over 65 of activities being limited “a lot” or “a little” for those in the LA need, moderate need and wider needs groups.

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<sup>1</sup> ADLs: getting in and out of bed; washing face and hands; having a bath/shower and getting in and out of bath; dressing and undressing (including socks and shoes); using the toilet; eating, including cutting up food; taking the right amount of medication at the right times;

<sup>2</sup> IADLs: getting around indoors; getting up and down stairs; getting out of the house; shopping for food; doing routine housework or laundry; doing paperwork or paying bills.

<sup>3</sup> Scores of life satisfaction questions are considered one way of assessing (subjective) well-being, though can be criticised as somewhat superficial but the closest proxy available in the dataset. Like Dunatchik et al, we take among those with 2+ activity limitations those whose life satisfaction score is one standard deviation below the mean life satisfaction score of those with no impairments/needs as having low well-being. This corresponds to those scoring below 6.89, rounded to 7. Because the Care Act does not have a clear definition for well-being, councils can interpret the measure loosely, so that needs assessment may vary greatly between local authorities. Because of this we have also assumed that 3+ ADLs qualify under LA needs, regardless of SWB score.

**Table 2. Need for help with ADL/IADLs among disabled 65+ (England)**

	LA need	Moderate need	Wider need
	(a)	(b)	(c = a + b)
Activities limited a lot (severely disabled)	61%	17%	77%
Activities limited a little	15%	13%	28%
All with limitations	38%	15%	53%

*Source: Own calculations using HSE 2016-2018 (pooled three waves). 'Moderate need' means just 1 ADL (regardless of SWB score), or 2 ADLs and/or 2+ IADLs but with higher SWB; 'LA need' means 2 ADLs and/or 2+ IADLs & low SWB, or 3+ ADLs (regardless of SWB). 'Wider need' includes both moderate and LA needs.*

Of those who are severely disabled - a long-standing illness limits their activities a lot - 61% need help with 2 or more ADLs or IADLs and have a low subjective well-being, thus fitting our LA needs definition, while 77% need help with at least one ADL and/or 2 IADLs, fulfilling our wider needs definition. Only 15% and 28% of those whose long-standing condition limits their activities a little, fit our LA needs and wider needs definitions, respectively.

## How many hours of care are needed?

The next stage is to find the correspondence between care needs and care provision intensity, defined by the number of hours per week required to provide adequate care to meet needs.

### Staffing for 65+

Average hours required are based on information about current hours of formal care provision or commissioning by local authorities. Assuming current unit costs (a weighted average of independent sector and public sector costs) of £19 per hour of domiciliary care in 2019-20<sup>4</sup>, total spending on domiciliary care for the over 65s equates

<sup>4</sup> This unit cost is calculated as the weighted average of in-house unit costs (£33.09) and external provider unit cost (£17.48) taken from Table 51 of the SALT Collection 2019-20, LTS001b, NHS Digital, 2020. The

to an average of 11.9 hours of care received per week.<sup>4</sup> We use this figure for LA needs. This is close to the average hours of LA-commissioned domiciliary care of 12.8 reported in the PSSRU unit cost tables.<sup>5</sup>

Given the task-based, rationed approach of cash-strapped local authorities, this average of 12 hours is likely to represent an underestimate of the hours actually required for good relational care for those currently receiving LA care, since these are more likely to have higher needs than all those eligible for such care but not receiving it. However, this also means that when extending provision to all those eligible to LA needs, thereby covering more people with slightly less intense needs, the assumed 12 hours might be closer to the hours needed on average for good quality care across the whole eligible population.

For moderate needs we assume 2 hours of care per week so that the weighted average of both yields 9.1 hours for the wider need group, a figure close to the average 10 hours of formal care provided in 2010, when more of those with less severe needs were covered.<sup>6</sup>

### Staffing for under 65s

In order to estimate needs of the younger age group of adults (18-64), we have used a different method, since no data on care needs exists for this group. We assume the following, using FRS data:

- Only the severely disabled require care.
- All those aged 18-64 who currently receive domiciliary care funded by LAs are severely disabled.
- There were 214,100 adults receiving such LA care in 2019-20, 8.6% of the severely disabled population of that age<sup>7</sup>, receiving on average 21 hours of care per week.
- About 32% of the severely disabled received some form of care (formal or informal or both).
- About 26% of the severely disabled report learning difficulties in 2019-20, which is seen as a proxy for needing care as discussed in Idriss et al. (2020)<sup>8</sup>

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weights are 87% for external and 13% for in-house using job split by sector: 87% of home care jobs come from external LA-commissioned providers and 13% from in-house public (LA or NHS) providers as indicated by Skills for Care (2020)

- We assume that 26% of severely disabled under 65s have care needs of similar intensity to those currently receiving LA support, requiring on average 21 hours of care per week.<sup>5</sup>
- The remaining severely disabled may have some care needs (but we have no basis for estimating how many do or how much). We assume these to be included in the moderate needs group and in receipt of 2 hours of care on average per week (as assumed for the over 65s moderate needs group).

## Staffing for all adults

Table 3 shows the population with care needs in each age group, the hours assumed to be required by type of need, and the number of FTE care workers per recipient. For consistency, FRS 2019-20 population data has been used throughout.

**Table 3. Domiciliary care staffing requirement by age group – England<sup>6</sup>**

	18-64	65+	All 18+
<b>Population with needs</b>			
LA needs	650,000	1,642,000	2,291,000
Wider needs	2,485,000	2,306,000	4,791,000
<b>Hours of care per recipient</b>			
LA needs	21.0	11.9	14.5
Wider needs	7.0	9.0	8.0
<b>Recipient-to-care worker ratio</b>			
LA needs	1.2	2.0	1.7
Wider needs	3.5	2.7	3.0

*Source: Own calculations using HSE and FRS microdata*

Adding the residential care population; there were 300,000 self-funding and LA-funded residents in care homes (83% of whom were aged 65+),<sup>9</sup> and 384,000 care home workers in England in 2019 (personal care workers or nurses).<sup>10</sup> This corresponds to one recipient per 1.27 FTE worker. For residential care, we count the costs of care provision (including practical help for IADLs and socialising) but omit hotel costs.

<sup>5</sup> Using a calibrated 65% take-up explained below means that about 17% of the severely disabled would receive LA care, which is double the current number of recipients, in line with the care gap that has been identified by Idriss et al. (2020), when comparing trends in the population with learning difficulties and that receiving LA-funded care over the last ten years.

<sup>6</sup> Calculated by assuming that 19% of the hours worked are travel time, 37 full-time working hours per week correspond to 24.2 hours of care per week (allowing for holidays, sickness, training time)

### Other staffing

For each model, we have added a preventative visit for all people aged 75+ based on the Danish system, with a 3-hour visit every year. This adds 8,420 FTE nurses. Such visits are particularly effective where services are available to those with wider needs.

## Wages and wage costs

Three models of wage costs have been estimated:

- **Current:** The current average wages of care workers across private and LA-funded clients.
- **Living Wage:** carers are paid the Real Living Wage.
- **Nordic model:** carers are paid at 75% of nurses' wages (this is relatively constant across Sweden, Denmark and Norway, at 75-78%) and trained to higher qualifications.<sup>11</sup> We assume training staff required at 0.004 FTE per care worker.<sup>7</sup>

Current average wages of personal carers differ according to whether we use ASHE data (£9.98 per hour)<sup>12</sup> or the PSSRU unit cost information (based on NHS digital and LA records (£8.87 per hour)<sup>13</sup>. We use the latter as a proxy for current wages.

The Real Living Wage was £9.50 per hour on average in 2019-20 (weighted average of London and out-of-London wages) so close to the ASHE median wage of a personal carer. We use £10 as an intermediate pay rise scenario, on the grounds that the Living wage should be the minimum, not the average. The PSSRU unit cost tables show average annual wages for nurses of £33,800 in 2019-20.<sup>14</sup> Such salary levels work out at £17.58 an hour, 75% of which would be £13.19. This is 96% of the median hourly wage of all employees (at £13.68 for 2020).<sup>15</sup>

The hourly pay rise from the current to the Real Living wage would be 13%, and to the Nordic levels, 49%.

Wage costs per FTE are determined by topping up increased wage levels by employers' National Insurance contribution of 13.8% and a superannuation contribution of 20%. However for current wages and conditions, we reduce the superannuation contribution to 4% and reduce travel time and holiday provision to match current practice by most private employers and give an average unit cost per FTE of £18.98. This means that the unit cost in the living wage model, at £26.77, is 41% higher than in the current model. In

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<sup>7</sup> Based on two-year training with 25 students per trainer, assumed to be paid at the same level as nurses, with skills acquired lasting for 20 years .



the Nordic model of qualifications and wages, the unit cost is £33.21 per hour, 75% higher than in the current model.

## Overheads

Home care workers attract overheads of £9,589 per FTE.<sup>16</sup> We assume the same figure for all staff, including in residential care. At current pay levels, these correspond to 45% of wage costs and at Nordic pay levels it would represent 30% of wage costs. Residential care home staff costs represent 69% of total costs (private homes), excluding accommodation costs<sup>17</sup> which imply that non-accommodation overheads (including profits) represent 45% of staff costs at current wages, in line with domiciliary care.

## Total annual costs

Table 4 summarises all the main costing assumptions and content of six scenarios shown in Table 5.

**Table 4. Main assumptions for costings of social care**

<b>Eligible needs (domiciliary)</b>	
Wider	<b>65+</b> : 1+ ADL or 2+ IADLs which covers 23% of all 65+; <b>18-64</b> : all severely disabled, ie 7% of 18-64 <b>18+</b> (weighted average): 11% of 18+
LA	<b>65+</b> : 2+ ADL/IADLs & low life satisfaction score (0-7) or 3+ ADLs, which covers 17% of 65+; <b>18-64</b> : 26% of severely disabled (2% of 18-64) <b>18+</b> : 5% of 18+
<b>Hours of care</b>	
Domiciliary 65+	11.9 hours p.w. for LA needs and 9 hours p.w. for wider needs (weighted average)
Domiciliary 18-64	21 hours p.w. for LA needs and 7 for wider needs (weighted average)
Residential all ages	31 hours p.w. (1.27 FTE per recipient)
<b>Wages levels</b>	

Nordic	£13.19 hourly wage based on 75% of nurses' wages, corresponds to £33 unit cost
Living	£10 hourly wage (slightly above Real Living Wage 2019-20), corresponds to £27 unit cost
Current	£8.87 hourly wage, corresponds to £19 unit cost
Overheads	£9,589 per FTE

Table 5 estimates total annual costs for six different scenarios at three pay scales, and two needs levels. It does this for four different levels of 'take-up' or 'reach' based on the following assumptions:

**For the over 65s:**

- **Current take-up (30%)** reflects both private and state-subsidised formal care, combining domiciliary and residential care recipients. This is not the proportion of those eligible for LA-funded care who take it up, but the proportion of those with 'high' care needs (defined as having 2+ ADL difficulties) who currently receive LA-funded or self-funded formal care. This take-up of recipients translates into a 45% 'take-up' in terms of care hours and thus staffing requirement. By construction, residential care take-up is 100% and invariant.
- **39% take-up** is the weighted average of the proportion of all those eligible for free personal care who receive domiciliary care in Scotland (about 29%), and 100% of those in residential care (state or self-funded combined).<sup>18</sup> This take-up of recipients translates into a 49% 'take-up' in terms of care hours and staff requirement.
- **68% take-up** assumes everyone living at home with care needs takes up the domiciliary care offered except those who receive informal care between 1 and 19 hours per week (whether or not their needs are met by this), based on HSE data. This is 65% of those with wider care needs, which combined with 100% of the care home residents, yields a take-up of 68%. This take-up of recipients translates into a 74% 'take-up' in terms of care hours and staff requirement
- **100% take up** if all those who need care eligible for formal state-subsidised free care take it up.

**For the under 65s:**

- We assume **68% take-up** throughout (except for when we look at 100%) on the assumption that means-testing has little effect on current take-up rates, since severely disabled under 65s tend to have low incomes and few savings. This is a weighted average of 65% take-up of domiciliary care and 100% residential care. We calculate this current domiciliary care take-up rate to be that which would make the total number of formal care workers, including those for the over 65s, match the current number of FTE formal personal carers (1.16 million FTE employed in care, of which 824,000 are personal care workers).<sup>19</sup> This take-up of recipients translates into a 69% ‘take-up’ in terms of care hours and staff requirement

Figures in Table 5 are based on 2019-20 data shown in 2021-22 prices,<sup>20</sup> and adjusted for increased demand. Total annual costs have been increased at the same rates as those used by the Health Foundation report of February 2021 (of 3.6% per annum in real terms to meet rising demand)<sup>21</sup>. All figures in Table 5 include a fixed amount of £4.6 billion representing the current (2021-22) public spending plan on non-care costs such as means-tested state-funded hotel costs, assessment costs and admin costs, which are assumed to stay constant across scenarios.<sup>8</sup>

**Table 5. Total formal care costs at various take-up rates (England - £m) in 2021-22**

Scenario	Needs	Pay	Take-up rates (domiciliary care) for			
			Under 65s / Over 65s			
			68% / 30%	68% / 39%	68% / 68%	100% / 100%
1	LA	Current	30,770	32,026	39,697	53,456
2	Wider	Current	32,668	34,016	42,242	57,000
3	LA	Living	39,945	41,641	<b>52,001</b>	70,584
4	Wider	Living	44,077	45,973	57,543	78,299
5	LA	Nordic	48,597	50,709	63,604	86,737
6	Wider	Nordic	53,749	56,109	<b>70,514</b>	96,355

<sup>8</sup> Calculated using 2019/20 from the SALT data by LAs. Accommodation costs represents 15% and 19% of total nursing and residential care home costs respectively (Tables 1.1 and 1.2 of PSSRU unit cost data). Client contributions represent about 16% of LA gross spending (SALT data), and we assume this proportion to be constant across the care, admin/ assessment, and hotel cost spending. We calculate that, as a result, the net public spending on non-care aspects represents 23% of the net overall LA current spending plus Better Care Fund, or £4.5bn (=23% of £19.5bn) in 2019-20 (in 2021-22 prices), and £4.6bn in 2021-22.

*Source: own calculations. Figures in 2021-22 prices. Costs in scenarios below the 100% take-up assumption are not proportional to the weighted take-up rates of the two age groups in terms of number of recipients because they account for the care intensity (number of care hours) of each group as well as fixed costs (admin and hotel costs).*

Table 5 reads as follows, assuming current levels of take-up (first column):

- Row 1: Providing free social care (under Care Act 2014 definition) at current wages and unit costs would raise spending by £11bn from £20bn to £31bn.<sup>22</sup>
- Row 3: Providing free social care together with higher wages and better working conditions as the most urgent policy while focusing on LA needs would require spending to rise from the current £20bn to £40bn.
- Row 4: Expanding needs to the wider group as recruitment grows would increase spending to £44bn, enabling more preventative care.<sup>9</sup>
- Row 6: Improving care and jobs quality by increasing training (two-year post-secondary diploma) and paying wages accordingly, based on Nordic levels, would increase spending to £54bn.

As levels and quality of provision increase it is likely that take-up rates will increase. Based on Scottish figures, 39% take-up rates for over 65s are more likely (column 2). This means a total annual bill of £42bn at Real Living Wage for LA needs (row 3), and £56bn at Nordic wages for wider needs (row 6).

Higher take-up at around 68% for over 65s would be in line with the aim of the Care Act to relieve pressure on those providing long hours of informal care (Column 3). This would add up to £52bn per year in 2021-22 at Real Living Wage covering LA needs (row 3), and £71bn at Nordic wages covering wider needs (row 6). The corresponding figure for 2019-20 (before the COVID-19 impact on the economy) in the latter scenario would be equivalent to 3.42% of English GDP, in line with public spending on long-term care in 2019 in Norway (3.45%) and Denmark (3.42%).

Take-up rates of near 100% may seem implausible but they are included to emphasise that significant informal care provision would remain in all scenarios for both those in the LA needs and wider needs categories. Indeed, replacing all informal care with formal care would require 33 care hours per week on average for those over-65s with wider need<sup>10</sup>. This would cost nearly three times as much as even the most comprehensive provision (scenario 6) in which compared to replacing all informal care by formal care,

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<sup>9</sup> Expanding care to the wider needs group could prevent progression in care needs and thus reduce numbers in the LA needs group. We have not allowed for any savings that this might generate overall.

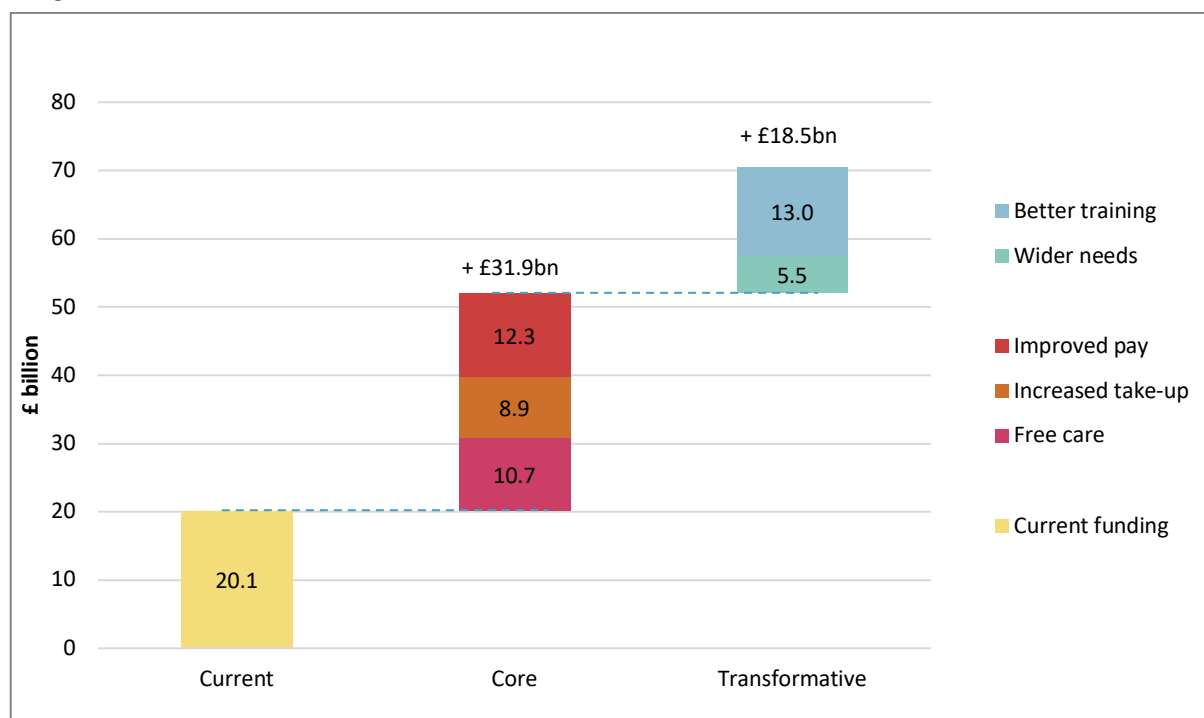
<sup>10</sup> Calculated from HSE data for all over-65s whose needs are fully met by paid and unpaid care.

informal care is ‘saving’ the public purse about £185bn at 100% take-up rates, more than the entire NHS budget excluding Covid-19 measures.<sup>23</sup>

We suggest focusing on two main models, both assuming take-up rates of 68%. The first - abolishing the means-test and raising wages to Real Living Wage - is the core scenario recommended in this report. Beyond this immediate priority, a transformational care system would extend services to a wider group with moderate care needs while increasing the quality of care through higher levels of training and pay.

- ‘Core’ (scenario 3 in Table 5 at 68% take-up): £52bn or 2.5% of GDP, which is £32bn above current public spending power (Chart 1)
- ‘Transformative’ (scenario 6 in Table 5 at 68% take-up): £71bn or 3.4% GDP, which is a further £19bn above the core scenario (Chart 1)

Chart 1. Cost elements of ‘Core’ and ‘Transformative’ scenarios for social care - England (2021-22)



Source: Own calculations. Figures in 2021-22 prices

## Comparison with Health Foundation estimates

The Health Foundation (2021) did some estimates of the funding gap compared with current plans as of February 2021 (before the 2021 September announcement). They calculate the additional costs in 2021-22 and projected annually until 2030-31 of

- keeping up with rising demand

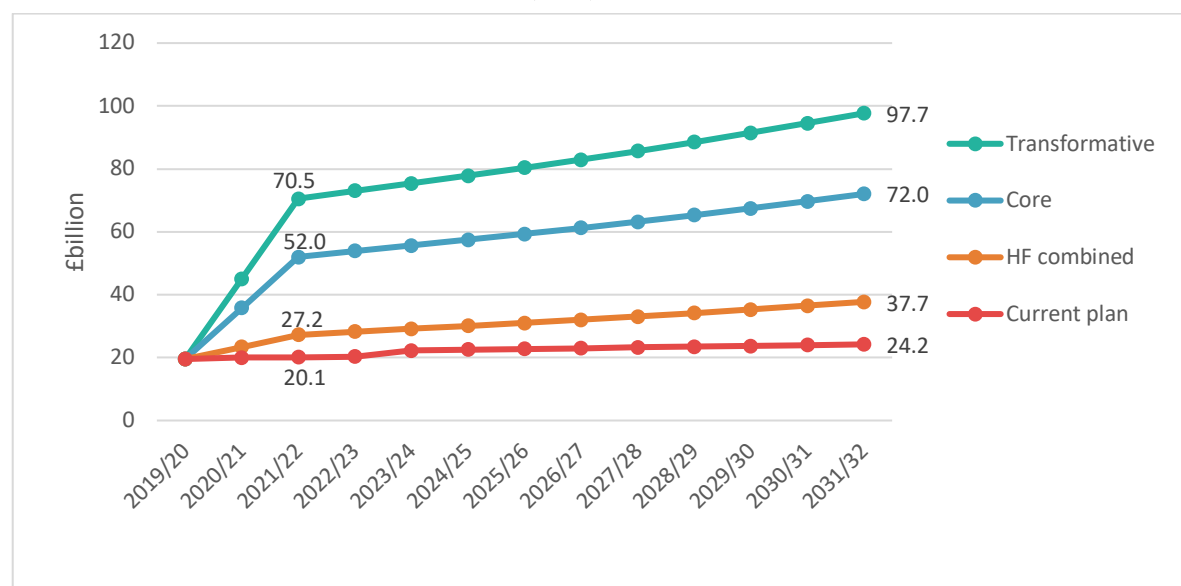
- increasing care packages by 10% to improve access to care
- increasing the amount local authorities pay for care to reach the hourly rate for domiciliary care calculated by the Home Care Association, estimated to require a rise of 18%, at current wages (so this is not a pay rise for care workers)<sup>11</sup>.

We adapt the baseline current plans, which budget public spending power on adult social care in England at £20bn (as in Chart 1). To do so we add £1.8bn per year from 2023-24 and project spending to 2031-32. Chart 2 shows the baseline current plan, plotted against the Health Foundation’s most ambitious plan of combining all three effects above, and compared to the costings of the two main models that we have established above.

By comparison with (b) above, our estimates of increasing access to care would see the number of total hours of care provided increase by 101% in the core scenario and by 187% in the transformative scenario. By comparison with (c) above, the rise in pay for an hour of care in the core scenario would be 41%, and 75% in the transformative scenario.

### Chart 2 Evolution of spending requirements 2019-20 to 2031-32 (£bn – England)

Source: own calculations and Health Foundation (2021).



Notes: The 'Transformative' scenario estimates costs of providing access to care to all with wider needs at Nordic qualification levels and relative wage rates and assuming 68% take-up rates; the 'Core' scenario estimates costs of providing access to those with needs falling under the Care Act 2014 (LA needs) at the Real Living Wage and also assuming 68% take-up rates; the 'HF combined' scenario estimates costs of combining the three Health Foundation options of keeping up with demand, increasing care packages by 10% and increasing what is paid publicly for an hour of care by 18%. Figures for these three scenarios are projected until 2031-32 using the Health Foundation

<sup>11</sup> See details in the interactive spreadsheet downloadable at the bottom of the web page summarising the main results (<https://www.health.org.uk/news-and-comment/charts-and-infographics/REAL-social-care-funding-gap>)

demand growth rates (around 3.2%-3.3% from 2021-22 onwards). The 'Current' plan is as estimated by the Health Foundation except for the additional £1.8bn announced by the government in September 2021 which we have added each year in real terms over the period from 2023-24. Unlike for the other scenarios, the current planned spending growth rate is 1.04% a year in real terms. All figures are in 2021-22 prices.

## Employment and tax revenue

Table 6 gives some estimates of employment created (increase in labour demand), tax revenue recouped and projections of gross and net costs now and in ten years' time.

Table 6 gives total number of FTE jobs created by the investment in care required for the two 'Core' and 'Transformative' models outlined above. It takes account of the jobs directly and indirectly created by that investment as well as the induced employment resulting from the increased economic activity of those newly employed or with increased wages. The table gives new jobs over and above the number of FTE care workers currently employed.<sup>12</sup>

**Table 6. Estimates of employment creation, tax revenue and gross and net cost projections**

	Core	Transformative
<b>New FTEs (2021-22)</b>		
Care sector	663,000	888,000
Total	928,000	1,355,000
<b>Spending levels (£bn)</b>		
Gross additional spending 2021-22	31.9	50.4
Tax intake	14.0	24.8
Additional spending net of tax intake	17.9	25.6
Tax as % of gross additional spending	44%	49%
<b>Spending levels (£bn) 2031-32</b>		
Gross additional spending 2031-32	47.8	73.5
Tax intake	21.0	36.1
Spending net of tax intake	26.8	37.3

Source: own calculations

<sup>12</sup> which was 1,160,000 in 2019-20, including direct care workers and other jobs in care. We have assumed this baseline figure to grow at the same annual rates as the costing projections.

Table 6 also shows the current unemployed population plus an estimate of those who are not employed and provide long hours of informal care, who could be freed to participate in the labour market by increased public provision.<sup>13</sup> This shows that this potential labour supply would currently be sufficient to ensure net new job creation in the short-term, but whether such jobs result in net new jobs in practice in the medium to long-term would depend on the state of the labour market then, especially in light of uncertainties surrounding the Brexit and COVID-19 developments, such as migration policies.

Table 6 also shows the increased revenue from taxes paid by those newly employed which reduces the net costs of such investment. This tax take is calculated as direct taxes (PIT, NIC employee and NIC employer) on wages paid to care workers in each model plus indirect taxes (at 16% incidence on gross wages<sup>14</sup>). Non-care jobs are assumed to be paid at average wages. This shows that 44% of gross annual spending is 'recouped' by tax revenue in the 'core' scenario, and 49% in the 'transformative' scenario, assuming all employment is new employment.

The last line of Table 6 shows that projected demand increase would raise total gross and net spending by 39% by 2031-32 (in real terms at 2021-22 prices, assuming current tax rules). Assuming a modest real GDP growth of 1.5% per year, this would bring total gross spending on adult social care to 3.4% of GDP in the 'core' scenario and 4.6% in the 'transformative' scenario.<sup>15</sup>

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<sup>13</sup> Using FRS 2019-20 microdata, projected to 2021-22 assuming overall population's rate of increase

<sup>14</sup> Using average incidence of indirect taxes on original income of households (in decile groups 2 to 8), based on ONS series on effect of taxes and benefits on household income (<https://bit.ly/3BjoCtL>).

<sup>15</sup> With 2% (1%) annual GDP growth, figures would be 3.2% (3.5%) and 4.4% (4.8%) respectively.



## ENDNOTES

- <sup>1</sup> Gov.uk. Definition of disability under the Equality Act 2010. Retrieved from: <https://www.gov.uk/definition-of-disability-under-equality-act-2010>
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- <sup>7</sup> NHS Digital. (2020). Adult Social Care Activity and Finance Report, England – 2019-20. Table 39, LTS001b. Retrieved from: <https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20>
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- <sup>9</sup> ONS (2020). Care home and non-care home populations used in the Deaths involving Covid-19 in the Care sector article, England and Wales. Retrieved from: <https://bit.ly/3zfHXLE>. Figures show residents during the year so we have adjusted the number with the proportion of residents at a given time (end of March) in the total population of residents (72%), as given by the NHS Digital SALT collection for 2019-20 (comparing Tables T39 with T34)
- <sup>10</sup> Skills for Care (2019). The Size and Structure of the Adult Social Care Workforce.
- <sup>11</sup> StatBank (Denmark, <https://www.statbank.dk/statbank5a/default.asp?w=1280>), StatBank (Norway <https://www.ssb.no/en/statbank>) and SCB (Sweden <https://www.scb.se/en/>)
- <sup>12</sup> Annual Survey of Hours and Earnings (ASHE), 2020 provisional tables, by occupation (table 14), <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/occupation4digitsoc2010ashetable14>
- <sup>13</sup> PSSRU unit cost tables <https://www.pssru.ac.uk/pub/uc/uc2020/3-communityscstaff.pdf> (section 11.5)
- <sup>14</sup> PSSRU unit cost tables <https://www.pssru.ac.uk/pub/uc/uc2020/2-communityhcestaff.pdf> (section 10.1)
- <sup>15</sup> Annual Survey of Hours and Earnings (ASHE), 2020 provisional tables, by occupation (table 14), <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/occupation4digitsoc2010ashetable14>
- <sup>16</sup> PSSRU unit cost tables <https://www.pssru.ac.uk/pub/uc/uc2020/3-communityscstaff.pdf> (section 11.5)
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- <sup>22</sup> *Ibid*
- <sup>23</sup> The King's Fund. (2021). The NHS Budget and how it has changed. Retrieved from: <https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-budget>