Summary: Intervention & Options

Department /Agency: Department of Health	Title: Impact Assessment of the Care and Support Green Paper	
Stage: Green Paper	**Version:** 1.0	**Date:** 14th July 2009
Related Publications: "The Case for Change - Why England needs a new Care and Support System"		

Available to view or download at:

http://www.careandsupport.direct.gov.uk

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What is the problem under consideration? Why is government intervention necessary?

With changes in demographic trends predicted, more people will need care and support in the future. The current system is ill equipped to meet future demand pressures and is regarded to be unfair,difficult to access and unsustainable. If left unreformed, a lower proportion of people in the future will have their basic needs met through social care, with knock on effects on other services such as the NHS. Government intervention is necessary to provide a simple, fair, affordable and sustainable system of care and support which will be able to meet future pressures.

What are the policy objectives and the intended effects?

As part of our aspiration to build a stronger, fairer Britain, we want to build the first National Care Service in England. The Government's vision is for a system that is fair, simple and affordable for everyone, underpinned by national rights and entitlements but personalised to individual needs. In the new National Care Service, everyone should be able to get really good care wherever they live and whatever they or their family needs.

What policy options have been considered? Please justify any preferred option.

The options outlined within the Green Paper are structured under three broad headings:

- **The vision for the future:** Information & Advice; Preventative Interventions; Assessments
- **Making the vision a reality:** Better joined up services; a wider range of care and support services
- **Funding Options:** Making the best use of existing funding; Bringing in new money; Accommodation costs; Nationally or locally determined funding system;

The summary sheets (to follow) only outline the cost/benefit implications for the specific funding models outlined in the bringing in new money section.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects?

Further impact assessments estimating the projected costs and benefits more precisely of the chosen options will be carried out following the consultation.

Ministerial Sign-off For consultation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister: Date: 14th July 2009

Summary: Analysis & Evidence

Policy Option: 1 | **Description: Pay for yourself**

COSTS

ANNUAL COSTS		
One-off (Transition)	**Yrs**	
£ not quantified		
Average Annual Cost (excluding one-off)		
£ not quantified		

Description and scale of **key monetised costs** by 'main affected groups' This option would produce substantial savings for local authority social services which have not been quantified since the option would be unaffordable for many people in the future, especially people with high care costs. We would expect additional costs to the NHS due to escalating need levels.

Total Cost (PV) | **£ not quantified**

Other **key non-monetised costs** by 'main affected groups'

This option would have a negative impact on people with low incomes and high levels of need who would have previously been eligible for support under the current system and are now left without any support and unable to afford their care costs.

BENEFITS

ANNUAL BENEFITS		
One-off	**Yrs**	
£ not quantified		
Average Annual Benefit (excluding one-off)		
£ not quantified		

Description and scale of **key monetised benefits** by 'main affected groups'

n/a

Total Benefit (PV) | **£ not quantified**

Other **key non-monetised benefits** by 'main affected groups'

No additional benefit

Key Assumptions/Sensitivities/Risks

n/a

Price Base Year	Time Period Years	**Net Benefit Range** (NPV) **£ n/a**	**NET BENEFIT** (NPV Best estimate) **£ n/a**

What is the geographic coverage of the policy/option?			England	
On what date will the policy be implemented?			n/a	
Which organisation(s) will enforce the policy?			n/a	
What is the total annual cost of enforcement for these organisations?			£ n/a	
Does enforcement comply with Hampton principles?			n/a	
Will implementation go beyond minimum EU requirements?			n/a	
What is the value of the proposed offsetting measure per year?			£n/a	
What is the value of changes in greenhouse gas emissions?			£ n/a	
Will the proposal have a significant impact on competition?			No	
Annual cost (£-£) per organisation (excluding one-off)	Micro **n/a**	Small n/a	Medium **n/a**	Large **n/a**
Are any of these organisations exempt?	n/a	n/a	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices) (Increase - Decrease)

Increase of £ to be quantified | Decrease of £ to be quantified | **Net Impact** £ to be quantified

Key: **Annual costs and benefits: Constant Prices** | **(Net) Present Value**

Summary: Analysis & Evidence

Policy Option: 2 | **Description: Partnership**

COSTS

ANNUAL COSTS		Description and scale of **key monetised costs** by 'main affected groups'
One-off (Transition)	**Yrs**	The net costs to the state are estimated to be £0.9bn in 2014 falling to savings of £1.1billion in 2024. These are net extra ongoing costs to the care and support system in comparison to the current system. These are illustrative comparative costs suggesting the relative cost to the state of the different models. They are indicative only, and are based on a set of modelling assumptions, as well as estimates about likely mechanisms for implementation. If this funding model was implemented we would expect these costs could be substantially revised and refined depending on the funding available. Costs would have to be met from within the public spending envelope set for future spending reviews, which will be in line with the plans for fiscal consolidation set out at Budget 2009. There would also be one-off costs relating to the change of system, which are not quantified.
£ not quantified		
Average Annual Cost (excluding one-off)		
£ 0.9bn to £-1.1bn	11	**Total Cost** (PV) **£ roughly zero**

Other **key non-monetised costs** by 'main affected groups'

The groups affected would depend on the final design of any new system.

BENEFITS

ANNUAL BENEFITS		Description and scale of **key monetised benefits** by 'main affected groups'
One-off	**Yrs**	Older service users would save an estimated £1.4billion in 2014 rising to £1.9billion in 2024 in payments for care at point of need. There may be savings to the NHS due to lower levels of unmet need for social care, which are not quantified.
£ not quantified		
Average Annual Benefit (excluding one-off)		
£ not quantified		**Total Benefit** (PV) **£ not quantified**

Other **key non-monetised benefits** by 'main affected groups' Increased access to care and an expected reduction in unmet need among older people with high needs could lead to improved outcomes for service users and carers. In particular, people with moderate needs and high incomes (with savings over £23k) would gain from this system as previously they would not have been eligible for any state support.

Key Assumptions/Sensitivities/Risks For the purposes of the modelling, the estimates make a number of assumptions, including that funding from some disability benefits, for example Attendance Allowance (AA) could be drawn into the care and support system to deliver a new and better offer. The estimates are sensitive to some of these assumptions, including the funding available, future trends in disability, unit costs of care, and to the specifics of the system and as such are indicative only. The estimates may also vary depending on whether the system will be locally or nationally delivered.

Price Base Year 2006	Time Period Years 2014-24	**Net Benefit Range** (NPV) £ **n/a**	**NET BENEFIT** (NPV Best estimate) £ **n/a**

What is the geographic coverage of the policy/option?	England
On what date will the policy be implemented?	n/a
Which organisation(s) will enforce the policy?	n/a
What is the total annual cost of enforcement for these organisations?	£ n/a
Does enforcement comply with Hampton principles?	n/a
Will implementation go beyond minimum EU requirements?	n/a
What is the value of the proposed offsetting measure per year?	£n/a
What is the value of changes in greenhouse gas emissions?	£n/a
Will the proposal have a significant impact on competition?	No

Annual cost (£-£) per organisation (excluding one-off)	Micro n/a	Small n/a	Medium n/a	Large n/a
Are any of these organisations exempt?	n/a	n/a	n/a	n/a

Impact on Admin Burdens Baseline (2005 Prices)					(Increase - Decrease)
Increase of	£ to be quantified	Decrease of	£ to be quantified	**Net Impact**	**£** to be quantified

Key: **Annual costs and benefits: Constant Prices** **(Net) Present Value**

Summary: Analysis & Evidence

Policy Option: 3 | **Description: Insurance (Private)**

COSTS

ANNUAL COSTS		
One-off (Transition)	**Yrs**	
£ not quantified		
Average Annual Cost (excluding one-off)		
£ 0.9bn to £-1.1bn	11	

Description and scale of **key monetised costs** by 'main affected groups' The net costs to the state are estimated to be £0.9billion in 2014 falling to savings of £1.1billion in 2024. These are net extra ongoing costs to the care and support system in comparison to the current system. These are illustrative comparative costs suggesting the relative cost to the state of the different models. They are indicative only, and are based on a set of modelling assumptions, as well as estimates about likely mechanisms for implementation. If this funding model was implemented we would expect these costs could be substantially revised and refined depending on the funding available. Costs would have to be met from within the public spending envelope set for future spending reviews, which will be in line with the plans for fiscal consolidation set out at Budget 2009. There would also be one-off costs relating to the change of system, which are not quantified.

Total Cost (PV) **£ roughly zero**

Other **key non-monetised costs** by 'main affected groups' There will be additional costs for those who purchase private insurance cover although it is unclear what the costs of the premiums would be. It would be a matter for the market. The groups affected would depend on the final design of any new system.

BENEFITS

ANNUAL BENEFITS	
One-off	**Yrs**
£ not quantified	
Average Annual Benefit (excluding one-off)	
£ not quantified	

Description and scale of **key monetised benefits** by 'main affected groups'

Older service users would save an estimated £1.4bn in 2014 rising to £1.9bn in 2024 in payments for care at point of need. There may be savings to the NHS due to lower levels of unmet need for social care, which are not quantified

Total Benefit (PV) **£ not quantified**

Other **key non-monetised benefits** by 'main affected groups'

This option has broadly the same benefits as option 2, the Partnership model but there will be additional benefits associated with the insurance for those who choose to purchase it.

Key Assumptions/Sensitivities/Risks For the purposes of the modelling, the estimates make a number of assumptions, including that funding from some disability benefits, for example Attendance Allowance (AA) could be drawn into the care and support system to deliver a new and better offer. The estimates are sensitive to some of these assumptions, including the funding available, future trends in disability, unit costs of care, and to the specifics of the system and as such are indicative only. The estimates may also vary depending on whether the system will be locally or nationally delivered.

Price Base Year 2006	Time Period Years 2014-24	**Net Benefit Range** (NPV) **£ n/a**	**NET BENEFIT** (NPV Best estimate) **£ n/a**

Question	Answer			
What is the geographic coverage of the policy/option?	England			
On what date will the policy be implemented?	n/a			
Which organisation(s) will enforce the policy?	n/a			
What is the total annual cost of enforcement for these organisations?	£ n/a			
Does enforcement comply with Hampton principles?	n/a			
Will implementation go beyond minimum EU requirements?	n/a			
What is the value of the proposed offsetting measure per year?	£ n/a			
What is the value of changes in greenhouse gas emissions?	£ n/a			
Will the proposal have a significant impact on competition?	No			
Annual cost (£-£) per organisation (excluding one-off)	Micro n/a	Small n/a	Medium n/a	Large n/a

Are any of these organisations exempt?	n/a	n/a	n/a	n/a

Impact on Admin Burdens Baseline (2005 Prices) (Increase - Decrease)

Increase of	£ to be quantified	Decrease of	£ to be quantified	**Net Impact**	**£** to be quantified

Key: **Annual costs and benefits: Constant Prices** **(Net) Present Value**

Summary: Analysis & Evidence

Policy Option: 4 | **Description: Insurance (State-backed)**

COSTS

ANNUAL COSTS		Description and scale of **key monetised costs** by 'main affected groups'
One-off (Transition)	**Yrs**	This option has not yet been modelled. It is expected to have the same net costs to the state as the Partnership models (£0.9billion in 2014 and – £1.1billion in 2024) plus additional costs to the state in respect of the state-backed insurance. These are illustrative comparative costs and are indicative only, and dependent on the future design and likely mechanisms for implementation. If this funding model were to be implemented we would expect these costs could be substantially revised and refined depending on the funding available. Costs would have to be met from within the public spending envelope set for future spending reviews, which will be in line with the plans for fiscal consolidation set out at Budget 2009.There would also be one-off costs relating to the change of system, which have not been quantified.
£ not quantified		
Average Annual Cost (excluding one-off)		
£ not quantified		**Total Cost** (PV) **£ not quantified**

Other **key non-monetised costs** by 'main affected groups'

An initial estimate suggests that people who opt for the state-backed insurance, could pay around £20,000-£25,000 (very rough estimate.) The groups affected would depend on the final design of any new system.

BENEFITS

ANNUAL BENEFITS		Description and scale of **key monetised benefits** by 'main affected groups'
One-off	**Yrs**	The benefits of this option have not been quantified: they could be expected to exceed those of the Partnership option. There may be savings to the NHS due to lower levels of unmet need for social care, which are not quantified.
£ not quantified		
Average Annual Benefit (excluding one-off)		
£ not quantified		**Total Benefit** (PV) **£ not quantified**

Other **key non-monetised benefits** by 'main affected groups' This option would have broadly the same benefits as the Partnership model, plus additional benefits associated with insurance for those who choose to purchase it.

Key Assumptions/Sensitivities/Risks This option has not been modelled. However the estimates make a number of assumptions, including that funding from some disability benefits, for example Attendance Allowance (AA) could be drawn into the care and support system to deliver a new and better offer. The estimates are sensitive to some of these assumptions, including the funding available, future trends in disability, unit costs of care, and to the specifics of the system and as such are indicative only. The estimates may vary on whether the system will be locally or nationally delivered.

Price Base Year 2006	Time Period Years 2014-24	**Net Benefit Range** (NPV) **£ n/a**	**NET BENEFIT** (NPV Best estimate) **£ n/a**

What is the geographic coverage of the policy/option?	England			
On what date will the policy be implemented?	n/a			
Which organisation(s) will enforce the policy?	n/a			
What is the total annual cost of enforcement for these organisations?	n/a			
Does enforcement comply with Hampton principles?	n/a			
Will implementation go beyond minimum EU requirements?	n/a			
What is the value of the proposed offsetting measure per year?	£n/a			
What is the value of changes in greenhouse gas emissions?	£n/a			
Will the proposal have a significant impact on competition?	No			
Annual cost (£-£) per organisation (excluding one-off)	Micro **n/a**	Small **n/a**	Medium **n/a**	Large **n/a**
Are any of these organisations exempt?	n/a	n/a	n/a	n/a

Impact on Admin Burdens Baseline (2005 Prices)					(Increase - Decrease)
Increase of	£ to be quantified	Decrease of	£ to be quantified	**Net Impact**	**£** to be quantified

Key: **Annual costs and benefits: Constant Prices** **(Net) Present Value**

Summary: Analysis & Evidence

Policy Option: 5	Description: Comprehensive

COSTS

ANNUAL COSTS		Description and scale of **key monetised costs** by 'main affected groups'
One-off (Transition)	**Yrs**	The net costs to the state are estimated to be £3.4billion in 2014 rising to £3.8billion in 2024. These are net extra ongoing costs to the care and support system in comparison to the current system These are illustrative comparative costs suggesting the relative cost to the state of the different models. They are indicative only, and are based on a set of modelling assumptions, as well as estimates about likely mechanisms for implementation. If this funding model was implemented we would expect these costs could be substantially revised and refined depending on the funding available. Costs would have to be met from within the public spending envelope set for future spending reviews, which will be in line with the plans for fiscal consolidation set out at Budget 2009.There would also be one-off costs relating to the change of system, which are not quantified.
£ not quantified		
Average Annual Cost (excluding one-off)		
£ 3.4bn to £3.8bn	11	**Total Cost** (PV) **£31bn (estimate)**

Other **key non-monetised costs** by 'main affected groups' People over retirement age would be required to pay into a national insurance scheme. An initial estimate suggests people could pay around £17,000 -£20,000 (a rough estimate.) The groups affected would depend on the final design of any new system.

BENEFITS

ANNUAL BENEFITS		Description and scale of **key monetised benefits** by 'main affected groups'
One-off	**Yrs**	Older service users would save an estimated £2.8bn in 2014 rising to £5bn in 2024 in payments for care at point of need. There may be savings to the NHS due to lower levels of unmet need for social care, which are not quantified.
£ not quantified		
Average Annual Benefit (excluding one-off)		
£ not quantified		**Total Benefit** (PV) **£ not quantified**

Other **key non-monetised benefits** by 'main affected groups' With all basic care costs for people with high needs covered, we would expect no unmet need among older people leading to improved outcomes for service users and carers. In particular, people with moderate to high incomes (savings over £23k) would gain from this system as previously they would not have been eligible for any state support.

Key Assumptions/Sensitivities/Risks As there are so many variants within this model, this model has not specifically been modelled, however estimates have been drawn from comparable models, such as the tax-funded option. The estimates make a number of assumptions, including that funding from some disability benefits, for example Attendance Allowance (AA) could be drawn into the care and support system to deliver a new and better offer. The estimates are sensitive to some of these assumptions, including the funding available, future trends in disability, unit costs of care, and to the specifics of the system and as such are indicative only. The estimates may vary on whether the system will be locally or nationally delivered.

Price Base Year 2006	Time Period Years 2014-24	**Net Benefit Range** (NPV) £ **n/a**	**NET BENEFIT** (NPV Best estimate) £ **n/a**

Question	Answer
What is the geographic coverage of the policy/option?	England
On what date will the policy be implemented?	n/a
Which organisation(s) will enforce the policy?	n/a
What is the total annual cost of enforcement for these organisations?	n/a
Does enforcement comply with Hampton principles?	n/a
Will implementation go beyond minimum EU requirements?	n/a
What is the value of the proposed offsetting measure per year?	£n/a
What is the value of changes in greenhouse gas emissions?	£n/a

Will the proposal have a significant impact on competition?				No
Annual cost (£-£) per organisation (excluding one-off)	Micro n/a	Small n/a	Medium n/a	Large n/a
Are any of these organisations exempt?	n/a	n/a	n/a	n/a

Impact on Admin Burdens Baseline (2005 Prices)					(Increase - Decrease)
Increase of	£ to be quantified	Decrease of	£ to be quantified	**Net Impact**	**£** to be quantified

Key: **Annual costs and benefits: Constant Prices** **(Net) Present Value**

Summary: Analysis & Evidence

Policy Option: 6 | **Description: Tax-funded**

COSTS

ANNUAL COSTS		Description and scale of **key monetised costs** by 'main affected groups'
One-off (Transition)	**Yrs**	The net costs to the state are estimated to be £3.4billion in 2014 rising to £3.8billion in 2024. These are net extra ongoing costs to the care and support system in comparison to the current system. These are illustrative comparative costs suggesting the relative cost to the state of the different models. They are indicative only, and are based on a set of modelling assumptions, as well as estimates about likely mechanisms for implementation. If this funding model was implemented we would expect these costs could be substantially revised and refined depending on the funding available. Costs would have to be met from within the public spending envelope set for future spending reviews, which will be in line with the plans for fiscal consolidation set out at Budget 2009.There would also be one-off costs relating to the change of system, which are not quantified.
£ not quantified		
Average Annual Cost (excluding one-off)		
£ 3.4bn to £3.8bn		**Total Cost** (PV) **£ 31bn (estimate)**

Other **key non-monetised costs** by 'main affected groups'
The groups affected would depend on the final design of any new system.

BENEFITS

ANNUAL BENEFITS		Description and scale of **key monetised benefits** by 'main affected groups'
One-off	**Yrs**	Older service users would save an estimated £2.8bn in 2014 rising to £5bn in 2024 in payments for care at point of need. There may be savings to the NHS due to lower levels of unmet need for social care, which are not quantified.
£ not quantified		
Average Annual Benefit (excluding one-off)		
£ not quantified		**Total Benefit** (PV) **£ not quantified**

Other **key non-monetised benefits** by 'main affected groups' With all basic care costs for people with high needs covered, we would expect no unmet need among older people leading to improved outcomes for service users and carers. In particular, people with moderate to high incomes (savings over £23k) would gain from this system as previously they would not have been eligible for any state support.

Key Assumptions/Sensitivities/Risks For the purposes of the modelling, the estimates make a number of assumptions, including that funding from some disability benefits, for example Attendance Allowance (AA) could be drawn into the care and support system to deliver a new and better offer. The estimates are sensitive to some of these assumptions, including the funding available, future trends in disability, unit costs of care, and to the specifics of the system and as such are indicative only. The estimates may also vary depending on whether the system will be locally or nationally delivered.

Price Base Year 2006	Time Period Years 2014- 24	**Net Benefit Range** (NPV) £ **n/a**	**NET BENEFIT** (NPV Best estimate) **£ n/a**

What is the geographic coverage of the policy/option?	England
On what date will the policy be implemented?	n/a
Which organisation(s) will enforce the policy?	n/a
What is the total annual cost of enforcement for these organisations?	n/a
Does enforcement comply with Hampton principles?	n/a
Will implementation go beyond minimum EU requirements?	n/a
What is the value of the proposed offsetting measure per year?	£n/a
What is the value of changes in greenhouse gas emissions?	£n/a
Will the proposal have a significant impact on competition?	No

Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large
	n/a	n/a	n/a	n/a

Are any of these organisations exempt?	n/a	n/a	n/a	n/a

Impact on Admin Burdens Baseline (2005 Prices) (Increase - Decrease)

Increase of	£ to be quantified	Decrease of	£ to be quantified	**Net Impact**	**£** to be quantified

Key: **Annual costs and benefits: Constant Prices** **(Net) Present Value**

Evidence Base (for summary sheets)

The Care and Support Green Paper outlines a number of potential reforms to the funding and delivery of the care and support system. The potential impact of these reforms has been considered within this Impact Assessment. This Impact Assessment will focus on the:

a) background and problems with the current system
b) rationale for government intervention
c) options for reform considered within the Green Paper:
   - **The vision for the future:** information and advice; preventative interventions; assessments
   - **Making the vision a reality:** better joined-up services; a wider range of care and support services
   - **Funding options**: making the best use of existing funding; bringing in new money; accommodation costs; nationally or locally determined funding system.

Background

When the Welfare State was founded in 1948, society looked different. Life expectancy was shorter, some conditions that are now common were relatively unknown and many disabled children died in childhood. Cultural norms prevalent at the time meant that disabled adults had fewer rights and women would tend to provide care for their family. Because of this, when the National Health Service was founded, a similar system for 'social care' as it became known was not set up. The state provided support only for people who had no family and could not afford to take care of themselves, and no settlement on how the family, the individual and the state would share responsibility for providing the care and support that people needed was agreed.

However, changes in society over time have meant that this idea of how disabled people and older people are supported is outdated. With increases in life expectancy (as a consequence of medical advances and rising incomes) and a growing ageing population, it means that more people are now living longer than ever before. For example, by 2026 it is predicted that there will be twice as many people aged over 85 and four times as many over 100. In addition, people's expectations about what support they should receive is far higher than previous generations.

The current system is not seen to deliver the personalised, high-quality care that current generations and future ones will expect. In particular, the system (based on a combination of national and predominately local service provision) is seen to:

- be unfair and difficult to access due to a lack of transparency regarding eligibility
- have some disparity of service provision in different areas of the country
- not effectively meet all the needs of those who require care.

In 2007/08, the Commission for Social Care Inspection (CSCI) reported that around 1.75 million people used the social care system over the course of a year.[1] However, with the number of people who will need care and support set to increase substantially with a further 1.7 million more people expected to need care and support in 20 years' time, the state will not be able to offer these people the level and quality of support they need in the future, unless the system is reformed. As a result of the issues discussed above, in 2007, the Pre-Budget Report and Comprehensive Spending Review announced the Government's intention to publish a Green Paper in 2009 to assess the potential ways in which the care and support system could be reformed to meet future challenges.

The Green Paper presents a number of possible options on the future care and support system for public consultation. Depending on the outcome of the consultation process, further policy consideration and evaluation will need to be conducted. Therefore, all of the proposals and their implications outlined within the Green Paper and this Impact Assessment are dependent on the outcome of the consultation and subject to change.

Problems with the current system

There are a number of problems with the current care and support system which are considered below under three headings:
a) Demographic changes will increase demand for care
b) Lack of support and/or differing levels of support
c) Ineffective use of money.

[1] 2007/08 figure taken from Commission for Social Care Inspection (2009) *The State of Social Care in England in 2007–08*. The figure does not take account of the total amount of people who need care and support, just those in receipt of services and support.

These are discussed further below.

a) Demographic changes will increase demand for care

The Personal Social Services Research Unit (PSSRU) at the London School of Economics (LSE) undertook modelling for the Government of the scale of demographic change and the financial pressure that this represents for social care and other services for people with care and support needs[2]. The modelling work estimated that the current social care system would need to receive increases in funding of a minimum of 3.2 per cent in real terms growth per year each in order to maintain the levels of support provided currently (without assumptions about productivity gains, this could increase to 3.7 per cent in real terms per year[3]). This estimate is for older people only.

However, funding alone cannot ensure that the level of support provided will meet future demands. Reform of the overall system is needed to ensure that resources are used most effectively and the system is delivering good quality support for all. To illustrate this point, modelling by the PSSRU shows that even with a substantial growth rate increase of 2 per cent in real terms year on year, the demographic changes mean that despite these increases:[4]

- by 2012, the social care system would no longer be able to support the same proportion of people that it does currently (those with critical and substantial needs and those on low incomes)
- by 2026, around 50 per cent of people in the lowest socioeconomic groups[5] and with critical or substantial needs would get no state support. This is in comparison with an estimated 20 per cent (of people with critical or substantial needs) receiving no state support in 2009[6]
- alongside the social care system, demographic change will also drive up demand for disability benefits.

This makes clear that reform of the overall system and the way it is funded and delivered will be needed to help to ensure that resources are better used in the future, to support future users and meet growing expectations.

It should be noted that the modelling work was carried out based on a number of technical assumptions (for more detail, see **Annex C**). The PSSRU used Government Actuary's Department (GAD) projections of life expectancy and population size, as well as various projections based on the British Household Panel Survey (BHPS) dataset. In addition, the modelling for younger adults used projections by the Office for National Statistics on future immigration patterns and the size of the working age population. Due to the many variables in the modelling of future demographics and potential costs, the conclusions from the work are sensitive to changes. For example, if more disabled children survive to adulthood or if medical advances improve, then future costs to the system would alter. The current system as it stands does provide adequate support; however, there are some problems that need to be addressed if the system is to meet the challenges that changes in society present. These problems are considered below.

b) Lack of support and/or differing levels of support

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[2] Some of this modelling is set out in 'Analysing the costs and benefits of social care funding arrangements in England: technical report, Fernandez, J.L and Forder, J, PSSRU, 2009

[3] These figures assume that the unit costs of care increase by 2 per cent in real terms per year or, with productivity gains assumed, 1.5 per cent per year.

[4] Results from modelling work carried out by the PSSRU at the LSE.

[5] This is defined here as the bottom two income quintile.

[6] People may not be receiving formal support for a number of reasons because they may have a high degree of informal care, or they may live in an area that only supports people with critical needs when they are assessed as only having substantial needs. They may also just not approach their local authority.

- **Many people do not get help from the state towards paying for their care and support.** Consequently, many people have told us that the current system seems unfair to them. They are particularly worried that people who have worked hard and saved do not get state support, while people who have never saved may get their care and support free.

- **State funded care and support is often provided only when people have already developed high levels of need.** People have told us that they feel they only qualify for help from the state once their needs are well advanced. If they had received support when their needs were less advanced, they might have been able to stay independent and well for longer, or might have needed less support later on. The state will always need to focus on supporting people with the greatest need. But we feel that more can be done to prevent people getting to that level of need in the first place, and also to support people at particular points of crisis, such as recovering from an operation. Intervening early may help to ensure that the needs they have do not worsen, and that the support they are offered can help to give them back their independence, rather than merely meeting their care needs.

- **People with the same needs receive different levels of care depending on where they live.** Local authorities across England use the Fair Access to Care Services (FACS) guidance issued by the Department of Health to assess and determine eligibility for services; this aims to make such decisions more transparent. However, different authorities interpret the FACS criteria differently and so they differ in the levels of need they support. Some authorities provide support for care packages for people with moderate or higher levels of need, whereas some only provide support for the higher levels.

- Of course, there are many ways in which local authorities support people with low or moderate care needs (for example, through housing or leisure programmes). But knowing that a neighbouring local authority is supporting the cost of care packages for people with lower levels of need can contribute to the feeling of unfairness.

- People also find it unfair that when they move to a new area they do not know whether they will still get funding for their care and support. They often have to have their needs reassessed, and do not find out the results until after they have moved. As well as seeming unfair, people have told us that this can stop people who have care and support needs from moving home.

- **The different parts of the care and support system do not work together.** Although we talk about a care and support system, it is currently fragmented rather than being a single, joined-up system. So people often struggle to find a way through it. They can face multiple assessments from different agencies with seemingly different criteria for providing support. People may also have to navigate their way through social care services, the benefit system, the NHS and housing services, as well as the many different private and third sector organisations. People find it particularly difficult to understand where the boundary lies between NHS care and social care and what kind of conditions qualify for each.

- **The care system as a whole is confusing.** Many people have told us that it is not clear to them what makes up ‘care and support’, or what financial support they may be eligible for or entitled to. People do not know that they could be responsible for paying for much of their own care, and so they do not make proper preparations to meet the costs involved. Above all, people do not feel that they know where to go to find out about care, either to help them plan for the future or to help them deal with problems as they arise.

- **The system is not tailored to people’s needs**. Many people who receive personal budgets or live in an area with good services told us that services were excellent and helped them to achieve what they wanted to.

- But others told us that services are shaped around the convenience of service providers rather than their own needs. People have told us that they want a system that recognises the different priorities individuals can have during the course of their lives and ensures that their support suits those needs. And people do not always feel that they get enough information about why certain services are being chosen for them, or feel involved in the decision-making process. Greater consideration will be needed as to meeting the particular challenges that are faced in different areas, for example rural areas.

c) Ineffective use of money

- **Building the evidence on what works**. Although the evidence base is improving, there is still not enough information as yet on how to spend money most effectively in care and support. This is vital to ensure that people can get high-quality services that they can trust to meet their needs. It is also crucial if services are going to work well first time and give good value for money – whether they are paid for by taxpayers or people who need care and support.

- **Ensuring that different parts of the system work together effectively.** Having different sources and types of care and support makes the system very complicated for people. It also may not be the best way of using state resources. Some types of support may be trying to achieve the same outcomes and would work more effectively if integrated. The Audit Commission, for example, recently set out some guidance on how the NHS and local authorities could pool resources. Other funding may simply need to be better aligned. We want to ensure that state money is being used in as cost-effective a way as possible.

Rationale for government intervention

The rationale for government intervention is considered against the alternative of removing state support entirely for care and support, i.e. a purely private solution, and the impact that this would have on equity and efficiency within the care and support system.

Problems with purely private solutions

Purely private solutions, where the state removes any support to individuals and people are required to fund all of their own care with either savings/assets or through insurance, are not feasible.

Estimates suggests that around 2.6 million[7] people do not have financial resources sufficient to support them for more than a year of long-term care, even when taking into account all their income, savings and housing assets and therefore would not be in a position to fund all of their own care and support

In terms of **equity**, the private insurance market alone cannot support future care costs as:

- support would be based on ability and willingness to pay rather than need, risk and ability to benefit. Those on low/medium incomes would find it difficult to access insurance
- Uncertainty in the existing arrangements of the system, particularly the potentially high costs of care and market failures (around difficulty to predict future need levels and cost of care as a result[8]), make it difficult for even a private insurance market to operate. Therefore current or potentially available financial products are not affordable for people with low or moderate levels of income and assets (those more prone to higher costs in the future).

[7] Mayhew L (2009) *The Market Potential for Privately Financed Long-Term Care Products in the UK*. Cass Business School Actuarial Research Reports.
[8] See Annex A for further detail on why specific products fail.

- Consequently, if the private market were the only provider of care through supply of financial products, this would result in unmet need, poor quality of life or early morbidity, alongside a high reliance on informal carers.
- In addition, given demographic trends, it is likely that a small but growing proportion of people will face extremely high care costs in the future.

One solution to this problem would be to pool risk through state insurance or taxation, since a drawback of financial products is that they have limited risk pooling as they fail to cover a large majority of those at risk.

In terms of **efficiency**, for those with the wealth to benefit from the private market, there is a lack of financial products available, caused by several market failures including:
- demand-side problems, with people underestimating the risk that they will need long-term care in the future, having poor knowledge about their responsibilities or the potential costs, and a behavioural tendency to put off and undervalue the importance of decisions now that relate to future wellbeing[9]
- supply-side problems, particularly around predicting an individual's risk of needing care and the small shared risk pool **(see Annex A for further details on purely private solutions).**

Government intervention

Therefore, government intervention through a state system, which pools risk across the population is needed to help to ensure that:
- people with care and support needs have access to the support they need to stay as well as possible for as long as possible
- people with care and support needs have an equal opportunity to achieve outcomes
- having family members with care and support needs would not prevent a person from having an equal opportunity to achieve outcomes, for example by making it more difficult to work or reducing the opportunity for social interaction.

In addition, government intervention can promote equity, efficiency and cost-effectiveness. These are discussed further below.

Equity

Government policy can fulfil equity functions in care and support by:
- helping people to protect themselves against the risk of needing intensive care and support
- improving horizontal equity (so people with similar needs get similar levels of support), or
- improving equity between generations (in terms of sharing the financial burden of support).

Efficiency

To promote **efficiency**, government could intervene to address overall failures in the market for care. Failures within the demand side particularly in relation to funding of care and care services include:
- a tendency for people to underestimate the risk that they will need long-term care in the future
- people's lack of knowledge about the potential costs of care and support, or how to prevent needs developing or reduce their needs
- a behavioural tendency for people to put off and undervalue the importance of decisions now that relate to future wellbeing, for instance by not saving for long-term care or making

[9] See, for example, Cabinet Office (2008) *Achieving Culture Change: A Policy Framework*.

changes to lifestyle, even if the risk of needing support and how to influence that risk **is** fully appreciated[10]
- people with care and support needs can have communication, cognitive or emotional difficulties that prevent them from acting as fully informed consumers without appropriate advice and advocacy.

Failures within the supply side relating to the overall supply of care in terms of insurance and provision of care services include:
- few financial products available to help people protect their assets or income (these are as a result of the market failures associated with being unable to estimate an appropriate premium due to the uncertainty about future levels of need and costs of care)
- failures in related markets (e.g. capital, housing, labour etc.), which can have serious knock-on effects for the care and support sector
- given the local nature of some support services, there can be a lack of effective competition.

There is also value in ensuring that all who have needs or are caring for others can maintain their health and reach their potential – that is, in technical language, there are 'positive externalities of consumption' from care and support that are not necessarily taken into account when people make decisions about their own private spending. In addition, society benefits from the knowledge that services exist and all who need care and support have their needs met in an appropriate and dignified way.

We believe that there is a strong case for the use of government financial support. It is unlikely that people in need of care and support, particularly those with intensive needs, would have an equal opportunity to economic wellbeing, safety and freedom from discrimination, and other key outcomes, without financial support. Care and support needs are simply too expensive for many to maintain.

Cost-effectiveness

Government investment can be justified on the basis of evidence on cost-effectiveness. There is evidence that suggests investment:

a) can prevent more expensive needs occurring:
- Social care spending can have a direct impact on health needs (and hence health spending) when invested in the most appropriate services in a well co-ordinated way.[11]
- There is evidence that social care can prevent readmission to health care when effectively targeted at the right people.[12]
- Good intermediate care can promote faster recovery and transition from high-cost acute care to more appropriate and lower cost care and/or then living independently within the community.
- An investment of £1.55 billion through Supporting People was found to produce a net financial benefit of £2.77 billion (shared between individuals and the Exchequer).[13]

b) ensures that people with needs and their carers can contribute to society:
- Informal family carers who undertake more than 20 hours of care a week are more likely to suffer from poor health[14] and to be out of work.[15]

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[10] See, for example, Cabinet Office (2008) *Achieving Culture Change: A Policy Framework*, and Chapter 6 of Pensions Commission (2004) *Pensions: Challenges and Choices – First Report of the Pensions Commission*.
[11] PSSRU, LSE for Health England (forthcoming).
[12] www.kingsfund.org.uk
[13] Supporting People evaluation.
[14] HM Stationery Office (2002) Carers 2000 National Statistics, using the General Household Survey.
[15] Family Resources Survey.

- It has been estimated that the total cost to the UK economy of absence from work due to ill health was £100 billion in 2006/07, a figure that could be reduced to an extent with appropriate support.[16]

c) brings 'peace of mind' to everyone in society:
- Personal care needs, closely followed by social participation, have been rated by people as their top areas of priority and factors that influence their quality of life most.[17]

The vision for the future

As part of our aspiration to build a stronger, fairer Britain, we want to build the first National Care Service in England. The Government's vision is for a system that is fair, simple and affordable for everyone, underpinned by national rights and entitlements but personalised to individual needs. In the new National Care Service, everyone should be able to get really good care wherever they live and whatever they or their family needs.

The care and support system must support people so that they can access the care and support they need and find out about the different kinds of support available. It must also be a system that helps people to live their lives the way they want to, supported by the staff who work with them. People who need services are often the experts in their own care, and the system for the future must respect this. People with care and support needs should be treated as citizens with rights, rather than having to fight to get services. Everyone who receives care and support must be treated with dignity and kindness, and their human rights must be respected.

The Green Paper also sets out what people can expect from a future system, which includes:

- The right support to help people stay independent and well for as long as possible and to stop your care and support needs getting worse. We call this **prevention services**.
- Wherever a person is in the country, their care and support needs will be assessed in the same way and they will have the same proportion of their care paid for. We call this **national assessment**.
- All the services that people need will work together smoothly, particularly when their needs are assessed. We call this **a joined-up service**.
- People can understand and find their way through the care and support system easily. We call this clear and easy access to **information and advice**.
- The services people use will be based on their personal circumstances and need. We call this **personalised care and support**.
- Money will be spent wisely and everyone who qualifies for support will get some help meeting the cost of care and support needs. We call this **fair funding.**

In developing potential options for reform of the care and support system, all the options originally considered have been assessed against the principles referred to, and those presented and considered as viable options within the Green Paper are seen to promote these underlying principles.

[16] Black C (2008) *Working for a Healthier Tomorrow*. The Stationery Office.
[17] OPUS project (Netten *et al* 2002), cited in Wanless D (2006) *Securing Good Care For Older People: Taking a long-term view*. King's Fund, p. 82.

Options for reform

1. **The vision for the future:** information and advice; preventative interventions; assessments.
2. **Making the vision a reality:** better joined-up services; A wider range of care and support services.
3. **Funding options**: making the best use of existing funding; bringing in new money into the system; accommodation costs; nationally or locally determined funding system.

Within each of the areas considered under the three broad headings above, specific options for reform have been presented within the Green Paper and are considered in the following sections of this Impact Assessment.

All of the specific options are evaluated against the option of 'do nothing', i.e. remaining with the status quo or current system. Costs and benefits of the do nothing option are assumed to be zero in that there are no additional costs and benefits of this option other than those which occur in maintaining the current system. The costs and benefits for all the other options are presented as the additional cost/benefit of each option relative to the do nothing option. Any net additional costs/burdens to local authorities identified would need to be fully funded.

1. The vision for the future

Information and advice

Current situation and challenges/problems faced
Evidence suggests that there are number of issues around the provision of information and advice to individuals within the current care and support system. These problems can be categorised as:

- **inaccessibility of information.** Access to information about the current care and support system is not clearly signposted and therefore it is up to individuals to approach their local authority or to find the information they require. However, the complexity of the current system means that there are difficulties in navigating and accessing advice about what services are available. Often people do not know where to start.
- **lack of information/advice provided.** Some local authorities provide information and advice to everyone in their area, but many only advise people who qualify for state-funded services. Some national voluntary organisations provide information but there is no easily recognisable national service. This means that people who need care, and their families, are often left alone to find their way through a highly complex system, with no support or advice. Some people miss out on the services that are available, simply because they do not know they exist, and many people do not know which services to choose or which are the highest quality.
- **variability of information.** Information and advice is seen as fragmented and locally dependent. Anecdotal evidence and recent research[18] both suggest that the quantity and quality of information services is, at present, variable.

The current transformation agenda
The Government's current transformation agenda seeks to improve the quality of information and advice available and has:

- **articulated a universal entitlement to information and advice within *Putting People First*.**[19] Local areas are expected to develop and own "a universal information, advice and advocacy service for people needing services and their carers irrespective of their eligibility for public funding. A 'first stop shop', which could be accessed by phone, letter, email, internet or at accessible community locations… Personal advocates to be available in the absence of a carer or in circumstances where people require support to articulate their needs and/or utilise the personal budget."[20]
- **committed to supporting local authorities** to reshape their work to achieve the transformation set out in *Putting People First* through a ring-fenced social care reform grant worth £520 million and lasting until the end of the 2010/11 financial year. There is also an enormous amount of work in train by a number of partner and stakeholder organisations. For example, the Department of Health has piloted work on information prescriptions[21] and is developing an information accreditation scheme; the Information Standard. It has also developed an online resource pack[22] to assist health and care organisations in introducing information prescriptions.
- **ensured better information for carers** with information available through the NHS Choices website and the new Carers Direct information hotline.

The Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) recently published a progress report on how well local authorities have

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[18] See, for example, the executive summary of Williams C et al. (2009) *Transforming adult social care: access to information, advice and advocacy*. Improvement and Development Agency.
[19] HM Government (2007) *Putting People First: A shared vision and commitment to the transformation of adult social care*.
[20] Ibid.
[21] See www.informationprescription.info
[22] See www.informationprescription.info/resource

implemented Putting People First during 2009.[23] It highlighted good progress made overall by local authorities in implementing the Putting People First programme, and that development of better local information and advice services which will be more widely available to everyone in their community is under way.[24]

However, the key question is whether existing policy will go far enough to ensure that the right information and advice services are available when they are needed. The limited and sometimes inadequate information provided means that there are issues of limited understanding and uncertainty around care services available, which limit people's ability to make informed decisions as to what services are suitable for them and whether they are getting value for money. Therefore, improving access to useful information and advice is needed and may need to go further than existing policy. Potential options for reform are considered below.

Options for reform

<table>
<tr><td colspan="2">Option 1: Do nothing means continuing with the current policies to transform adult social care. However, this option alone may not be sufficient to ensure adequate information is provided about the availability of care and support services, and how to access them.</td></tr>
<tr><td>Cost
Benefit</td><td>By definition, there are no costs or benefits associated with this option, as costs and benefits are measured in comparison with the status quo.</td></tr>
<tr><td colspan="2">Option 2: Create a national brand for care and support information and advice services to provide people with a clear starting point for accessing information and advice about care and support services. This is one possibility which could include many different policy proposals, from relabelling existing or currently planned services, to increasing services beyond those that already exist, all under a new banner; however, this proposal is still tentative and further work is required. This option may be altered following responses to the consultation.</td></tr>
<tr><td>Cost</td><td>• Costs are likely to involve marketing and signposting, ensuring that the brand is meaningful and expectations of services were met. This could raise demand for services as a result of greater awareness.
• Potential costs could be significant; however, further work is needed to quantify the exact costs. However, costs would be lower if the policy involved rebadging existing services to improve people's recognition.
• Further work required to understand specific costs as the policy develops. We can investigate these costs by looking at the costs of comparable work in the past.</td></tr>
<tr><td>Benefit</td><td>• Benefits cannot be specified until the work is much further developed.
• Potential benefits will vary considerably according to the specific policies agreed but overall this may lead to:
o more consistent or additional services across the country;and
o better access to and provision of information through a national brand.
All of the above will mean better user experience for people generally, and possibly better outcomes for individuals who will be more informed to make choices about the care they need.[25]</td></tr>
</table>

[23] Local Authority Circular (Department of Health) (2009) 1.
[24] www.adss.org.uk/index.php?option=com_content&view=article&id=480&Itemid=361
[25] Work is currently ongoing to enable the Department of Health to understand the user journey better, for example understanding how people currently access information and the barriers they encounter in doing so.

Role of preventative interventions and the evidence base

Current situation and challenges/problems faced
Under the current system, there are number of issues around access to and provision of interventions which could be considered as preventative.[26] These are:

- **lack of evidence/knowledge about preventative interventions.** Evidence about what preventative interventions[27] are effective in care and support is limited. Care and support is complex and it is very difficult to measure outcomes in social care. In addition, there is also a lack of clear evidence about the patterns of care, or 'care pathways' that lead to the best outcomes for people in return for the money invested. Therefore, it is difficult to understand what preventative interventions would lead to good outcomes, especially as the current evidence base on preventative interventions is still relatively weak. The Department of Health is investing in improving this evidence base.[28]
- **lack of information.** Even where evidence exists, it can vary considerably in its conclusions and is not readily available for consumers. This means that there is no obvious place to start looking for these products and services with which people are typically unfamiliar.[29] In addition, it may be difficult to find objective information, as profit-maximising producers have an incentive to sell to consumers who wouldn't necessarily need services.
- **lack of state support.** Currently, some interventions are not funded by the state or commissioned by local authorities. Therefore, it is left up to the individual to identify what is available and decide whether to spend money on them.
- **unaffordable preventative interventions.** People balance different choices and risks when deciding to invest in preventative measures, and we know that people tend to unduly discount the long-term gain from investing in preventative care for themselves in comparison with the short-term cost, especially if interventions are unaffordable (particularly for people on lower incomes). This tendency for people to think in the short term could be increased if some of the costs of failing to invest in preventative care (i.e. costs associated with poorer health in later life) would be paid by the state, for example in terms of costs to the NHS, rather than paid for by the person making the decision.[30]
- **lack of incentives in social care to generate savings, which are realised elsewhere.** Social care investment in prevention can lead to associated improvements in quality of life and benefits of avoiding unplanned inpatient care. However, any cost reductions are usually made in health care. Flexibility to transfer these savings back to social care does not always exist.

Failure to or inability to invest in these types of interventions may lead to sub-optimal outcomes for people in need of care and support, and could result in people experiencing poorer quality of life and health. It is also likely to lead to additional costs to the state, as escalating needs that are not managed or improved within social care result in people needing help from the NHS. We propose a number of options with regards to preventative interventions, which are considered in the following table.

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[26] For a discussion on what is meant by prevention, please see Annex B Prevention, part 1.
[27] Derek Wanless in *Securing Good Care for Older People* (2006) summarises the situation: "there is an urgent need to establish the cost-effectiveness of prevention and preventative services. There appears to be significant promise in this regard, but the evidence base is not yet sufficiently developed." See also, e.g. Evidence Cluster: Prevention, Ripfa, available at www.ripfa.org.uk/evidenceclusters/displayCLUSTER1.asp?catID=6&subcat=1
[28] Evidence is expected to become richer following the final evaluation of the Partnership for Older People, due later this year, the final evaluation of the Whole Systems Demonstrators programme (looking at telecare and telehealth) due in 2010, and the results of a long-term controlled study of reablement, concluding in 2010. In addition, last year saw the creation of a new National School for Social Care Research.
[29] See Annex B, part 2 for evidence from stakeholders on this.
[30] However, this would of course be likely to be a small effect relative to the human costs of illness, which would fall primarily on the individual person making the decisions about spending on preventative care (or, similarly, healthy behaviour throughout life, such as taking exercise and eating well).

Options for reform which were considered

The following options were considered. Their costs and benefits are described below:

<table>
<tr><td colspan="2">Option 1: Do nothing has been ruled out, as it is likely that the current situation has resulted in an inefficient under-consumption of preventative interventions.</td></tr>
<tr><td>Cost</td><td rowspan="2">By definition, there are no costs or benefits associated with this option.</td></tr>
<tr><td>Benefit</td></tr>
<tr><td colspan="2">Option 2: Invest only in improving the evidence. While investing in improving the evidence base is important, taking this action alone would not address the issues around information for people, people's focus on the short-term, incentive problems or social inequity so it has been ruled out.</td></tr>
<tr><td>Cost</td><td>
A wide range of options are available in terms of how the evidence-base is improved, with possibilities ranging from a new National Institute for Health and Clinical Excellence (NICE)-style body for social care, to build on work currently done by bodies such as the Social Care Institute for Excellence (SCIE). Clearly, the cost implications would vary considerably according to which option was selected.
Significant additional work is required to quantify in detail the cost (and benefits) of this option and other possible options.
The sources of costs are likely to be the costs of additional research required to improve the evidence base, and the set-up and running costs of a new institution or of new responsibilities for an existing institution, as well as any opportunity costs where an extant institution changed its focus. For comparison, NICE received funding in the region of £34 million in 2007/08.[31] This may be seen as a ceiling estimate of annual direct institutional costs, as any equivalent work in social care would build on current investment.
The main costs of improving the evidence base would depend on what new research was undertaken
</td></tr>
<tr><td>Benefit</td><td>It is difficult to quantify the benefits from improving the evidence base. This would depend on what the evidence showed, and how far it could be used to change practice.</td></tr>
<tr><td colspan="2">Option 3: Invest in improving the evidence around preventative interventions and the provision of information and advice about preventative interventions.</td></tr>
<tr><td>Cost</td><td rowspan="2">This would have the same costs and benefits as option 2 plus additional costs in creating useful information and advice relating to the evidence base. Please see the section on information and advice with regards to the possible costs and benefits involved in developing information and advice on preventative interventions. Further work would be required to understand the costs and benefits in more detail – this work could draw on previous experience with information provision, for example looking at costs associated with the recent Information Prescriptions work (see www.informationprescription.info/).</td></tr>
<tr><td>Benefit</td></tr>
<tr><td colspan="2">Option 4: Invest in improving the evidence, the provision of information and advice, and the provision of more state-funded cost-saving preventative interventions. Investing in all three areas would address all the issues considered previously and is therefore the preferred option. At this early stage in the policy process, the details of implementation are yet to be</td></tr>
</table>

[31] NICE (2008) *Annual Report and Accounts*. The Stationery Office.

finalised. However, where there is evidence that a given intervention is both cost-effective and cost-saving for government (as appears likely to be the case for re-ablement, for example[32]), there is a clear case for a standard universal offer of appropriately targeted services, free at the point of use. A clear national offer of effective preventative interventions would also improve people's awareness and understanding of the system, improving service take-up and therefore outcomes. In addition, evidence about which care pathways are most cost-effective, and work to promote use of those for people in particular circumstances, could improve outcomes for people and/or create savings for services.	
Cost	• Further work is required to better understand costs but the evidence base is already improving, with evidence from ongoing studies expected over the next couple of years. The Department of Health is working to improve the evidence base with a controlled two-year study on re-ablement due to report in 2010, which should help to provide further evidence. • The costs would be similar to option 3, plus the additional costs of providing cost-saving preventative interventions, for example set-up costs, staffing and training. By definition, the costs of such interventions would be recouped in later years, if the decision were made to invest only in those services that are cost-saving. (Further costs would be incurred in future years, if a better measurement of outcomes becomes possible, and if a decision were taken to invest in interventions that could be demonstrated to be cost-effective, as well as those that were cost-saving.) • The balance of evidence suggests that certain re-ablement services may be cost-effective and cost-saving when targeted appropriately. (Re-ablement aims to help service users to regain their independence, by relearning skills of daily living or by gaining new ones.) • While re-ablement is, hour for hour, more expensive than home care, many people do not need an ongoing home care package after a few weeks of re-ablement. A re-ablement package would typically pay for itself if a re-ablement user continued not to need ongoing care for around five to seven months,[33] where they would otherwise have required a typical care package. However, evidence on this is still inconclusive. • The key issue is lack of counterfactual information – it is difficult to establish whether and for how long people would have needed services in the absence of re-ablement programmes. Evidence on savings to the NHS is limited, although again anecdotally positive. • Indications are, however, positive. As of March 2009, over 90 local authorities have some form of re-ablement service already at least partially in place, and 29 are at various stages of establishing a re-ablement service.[34] Clearly, local authorities believe that there is scope for savings here – and, in a recent survey, 75 per cent of local authorities reported that they could see the benefits from their work on prevention, such as re-ablement. Local authorities typically assume that those people who enter re-ablement programmes would otherwise have received a home care package on an ongoing basis. The overall balance of evidence suggests that an offer of free re-ablement would be cost-effective (subject to the evidence staying positive when the results of the study due in 2010 become available) and would fit well

[32] See Annex B, part 3 for a look at the current evidence base on preventative interventions.
[33] Costs and break-even points vary for different people and different local areas. See Care Services Efficiency Delivery (2007) Homecare Re-ablement Work-stream, Discussion Paper.
[34] Homecare Re-ablement CSSR Scheme Directory, Update March 2009.

	within social care, given these services tend to be run and delivered by social care staff and have been designed in the social care context. It is therefore assumed that a universal offer of re-ablement services, for example for people leaving hospital, would be appropriate. However, this policy is still tentative and very much dependent on further conclusive evidence. The key costs here would be the direct costs of providing services. It is also likely that there could be potential cost savings, if it is proven that these interventions will help to prevent future needs escalating, which would require ongoing home care, admissions to care homes and use of other services. • The evidence on most other preventative interventions[35] in social care is still very weak and no clear decision can be taken on them at this time. • Currently, the commissioning of re-ablement services is a matter for local authorities (albeit with support from Department of Health-funded bodies such as Care Services Efficiency Delivery (CSED)). Further work would be required to understand in more detail the current pattern of services, and to understand how many extra people in each area could benefit. Until this information is available, it is not possible to estimate the additional costs (or benefits) of rolling out such services in every local area. • Using a high estimate that it would cost £1000 per re-ablement package, we believe it would be possible to offer re-ablement to people leaving hospital who would qualify for care and support from the state for the first time, subject to future funding decisions. This is the case even if the expected savings from re-ablement are not realised. • Further evidence will be available in October 2010 once the final report of the *Prospective Longitudinal Study for Homecare re-ablement* has been published.
Benefit	It is currently not possible to quantify exact benefits from providing more state-funded preventative services. However, we would expect to see benefits in terms of enhanced quality of life, improved health and reduced morbidity and need levels for service users. These would be in addition to the potential savings (negative costs) described.

[35] Excluding falls services, for which a NICE guideline already exists.

Assessment

Current situation and challenges/problems faced
In the current system, local authorities assess people referred to them to determine:

- eligibility for local authority care services
- care and support needs;
- access to a direct payment or individual budget;
- risk and capacity to make decisions or manage care; and
- financial means(including income from disability benefits) and liability to charges for care.

A number of issues with the current assessment process are considered. These relate to:

- **variability of assessment.** Each local authority operates within national guidance on fair access to care and on charging for social services, and within the same legal framework on risk and capacity. However, there are different outcomes between localities when the number of assessments undertaken and the range of services funded and supplied following assessment are compared. Typically, each authority is implementing the existing transformation programme to create separate resource allocation systems for different categories of service users – one for adults with learning disabilities, a second for adults with mental health needs, a third for adults with physical disabilities and a fourth for the larger group of older people. Even if all authorities were to adopt a standard assessment protocol and document, this would still result in up to 600 different possible outcomes for one set of defined needs or risks.
- **availability of assessment.** Currently, only those in greatest need get a full assessment. In some cases, local authorities provide information on their websites and in literature explaining that simple, low-level needs are unlikely to merit publicly funded care and encouraging people to seek help themselves. When people request an assessment (in writing, by phone, face to face, or via another service), the request will be screened (if possible by phone) to determine the likely need and to redirect it if it will not reveal substantial or critical needs. In 2006/07, there were just over 2 million referrals to local authorities for care assessment (45 per cent from families and people themselves, 35 per cent from the NHS). Of these, 800,000 led to a new assessment and 560,000 led to new services being provided. Some 554,000 new services were delivered within four weeks. So, just over a quarter of referrals resulted in a new service being provided within four weeks.
- **lack of portability of assessment.** As mentioned above, the variability of assessment process can mean that an individual can be assessed as having a different need level depending on which authority assesses them. This can make it difficult for individuals who wish to move, as they are unclear what their need level may be classed as and what support they will be entitled to under a different authority (for example, this can limit young disabled adults who wish to find employment elsewhere.) Therefore, portability of assessment is needed.

Given these issues, potential options for reform of the assessment process are considered below.

Options for reform

<table>
<tr><td colspan="2">Option 1: Do nothing has been ruled out as the current assessment system is an integral part of the problem that the reform addresses.</td></tr>
<tr><td>Cost</td><td rowspan="2">By definition, there are no costs or benefits associated with this option.</td></tr>
<tr><td>Benefit</td></tr>
<tr><td colspan="2">Option 2: Standardising the assessment process – creating a national assessment for care and support services across England would establish a new national benchmark, and provide citizens and care suppliers with a new set of expectations. It will be necessary to</td></tr>
</table>

establish new rules and, potentially, a new body to review rules and maintain compliance.	
Cost	• Main costs involve set-up costs of a new body (or a new function of an existing body) to design and create a nationalised assessment. This could be partially offset by removing the need for the 152 local authorities to maintain their own systems. However, this saving would be small as the existing systems are already in place. • The assessment will still be carried out by local authorities but there would be set-up costs. These arise from defining new rules, establishing a new review and compliance capability, training staff and informing the public. Set-up costs would be offset by a simpler system which imposed less delay and reduced costs on individuals and care suppliers and eliminated duplication of assessment when people moved from one service to another or from one locality to another. • Once in place, the new system could accrue efficiency savings over time, particularly if making a simpler assessment form widely available allows people to prepare for their assessments more thoroughly and reduces the time taken with an assesser. This may be offset by an increasing number of people seeking assessment – we will need to look at how the costs associated with the process of assessment can be reduced to counteract increasing demand.
Benefit	• Transparency of assessment and being able to transfer the findings of an assessment for one location to another would remove the huge barrier to portability which people currently face. • A standardised assessment process would enable people to access clear information before they chose to move about what implications this decision would have for the care they receive. • Making the assessment universal would remove the great perceived unfairness in the system, where people with seemingly very similar needs get different results from their assessments.

2. Making the vision a reality

More joined-up working between health, housing and social care services and between care and benefit services

This part of the Green Paper proposes that, as now, integration remains a locally led issue. It argues that central government needs to focus on making it possible to remove the barriers that prevent joined-up working. It also consults on what the barriers are. The recently established Ministerial Group on Integration of Health and Social Care Services will head this work within the Department of Health. It will promote better access to services, improved quality of services and greater public service productivity from joint working, through the approaches that have been shown to work best, as well as determining the role that government should be playing and the barriers that we need to remove.

There may be some costs and benefits associated with promoting greater joined up working, although these are uncertain at present and will require further work. Once consultation responses have been received, work may be undertaken to develop new proposals, at which point the costs and benefits associated with these proposals will be identified and quantified.

A wider range of care and support services.

Current situation and challenges/problems faced
The market for care is determined by demand and supply pressures. There are some problems with the current market for care which are discussed further below.

Issues with demand

- On the demand side, ‘care’ can be a complex range of services, not a simple product, so it can be hard to know what you need and hard to know whether you are getting value for money (there may be ignorance and uncertainty, complexity and limits to decision capacity, and information asymmetry).
- Entering residential care is something you may do only once in your life, and the decision to move from one residential placement to another is very difficult. (This means that there may be complexity and limits to decision capacity, transaction costs and, given that once a person is in one residential care home it can be very difficult to move, there may be a degree of monopoly power. There may also be monopoly power in the market where there are specialist services for small groups of users with specialist needs.)
- The decision to purchase care, particularly residential care, may often be made urgently and at a time of crisis and emotional strain (there may be complexity and limits to decision capacity). In many cases, commissioners may purchase care on behalf of people (there may be agency problems).
- Individuals in need of care and support may be in a vulnerable situation, and potentially open to abuse (there may be inadequately aligned incentives and issues of equity).

Issues with supply
The issues relate particularly to the provision of residential care. It is expensive to set up as a supplier of residential care, which means that there may be barriers to entry – these may result in lack of provision or lack of competition in some areas (monopoly power). Along with this, local authorities have historically had such market power that providers have not always been incentivised to cater to the diverse needs of those whose needs are not reflected in what local authorities purchase (monopsony power). This monopsony power may be reduced by current policy to increase use of personal budgets, which enable people to purchase non-traditional forms of support or to employ their own personal assistant.

The evidence available suggests that many suppliers, especially small, local businesses, feel restricted in their capacity to invest and change. The main constraints identified by care providers are:

- cost and volume restrictions from their main commissioners (i.e. local authorities)
- purchasing and procurement policies (either restricting the number of suppliers or favouring existing models of service)
- regulatory restrictions on diversification (the Care Quality Commission (CQC) registration requirements for exploratory ventures)
- access to development funding and business support
- shortage of skilled staff and planning controls.[36]

Of course, there is always a balance to be struck between encouraging innovation and protecting people who may be made vulnerable by their situation.

Current improvements to the care market

Clearly, these failures are likely, in the absence of government intervention, to lead to sub-optimal outcomes for people. People may not get the right care at the right time and, where competition is lacking, prices may be unduly high.

However, current policy is already working to address some of these issues. The Department of Health Local Authority Circular from March 2009[37] reiterates the aspiration set out in *Putting People First*[38] to transform social care, through a ring-fenced social care reform grant worth £520 million and lasting until the end of the 2010/11 financial year. The vision in *Putting People First* sets out several objectives that would directly address many of these market failures. For example:

- commissioning which incentivises and stimulates quality provision offering high standards of care, dignity and maximum choice and control for service users
- social workers spending less time on assessment and more on support, brokerage and advocacy
- universal information, advice and advocacy
- support for at least one local user-led organisation and mainstream mechanisms to develop networks which ensure that people using services and their families have a collective voice, influencing policy and provision
- systems that act on and minimise the risk of abuse and neglect of vulnerable adults, supported by a network of 'champions', including volunteers and professionals, promoting dignity in local care services
- personal budgets for everyone eligible for publicly funded adult social care support other than in circumstances where people require emergency access to provision.

The key question is whether existing policy will go far enough to ensure that the market failures are sufficiently overcome – in particular, whether there are sufficient measures to overcome the supply-side issues. The Green Paper considers a number of ways in which the market for care could be improved, which it consults on. These are discussed below.

Options for reform

Option 1: Do nothing means continuing with the current policies to achieve a system-wide transformation in adult social care.	
Cost	

[36] Resolution Foundation (2008) *Navigating the Way: the future care and well being of older people.*
[37] Available at H:\Social Care Strategy Unit\Green Paper\Policy phase II - post launch document\System\LAC (DH)(2009)1 Transforming Adult Social Care Department of Health - Publications.htm
[38] HM Government (2007) *Putting People First: A shared vision and commitment to the transformation of adult social care.*

Benefit	By definition, there are no costs or benefits associated with this option, as costs and benefits are measured in comparison with the status quo.
Option 2: Improving the wide range of care and support services. The Green Paper describes a number of activities that local authorities already do or could consider doing to encourage a wider range of care and support services as part of their broad commissioning responsibilities, and it asks readers to consider the following: o In order to make the National Care Service work, we will need services which are joined up, give choice around the kind of services people get and ensure they are high quality – what this would look like in practice and what are the barriers to making this happen. o Would it be appropriate to give an independent body the role of identifying what works well and is cost-effective in care and support?	
Cost	All proposals are at a very early stage, and have not been costed. Significant additional work is required to add detail to these very early proposals, to assess how far they could be expected to bring about the desired benefits and to begin to identify and quantity the detailed costs associated with each. Once consultation responses have been received, work may be undertaken to develop new proposals. At this point, the costs and benefits associated with these proposals will also be identified and quantified.
Benefit	All proposals aim to improve outcomes for people in need of care and support, through improving the functioning of the market for care and support services. As set out above, benefits have not yet been quantified.

3. Funding options

Current situation and challenges/problems faced

The costs of formal care and support services are shared between the state and people in need of care and support. Everyone pays in a limited contribution through general and local taxation, but state funding on social care is targeted towards those with highest needs and lowest means, so that those who are unable to afford their care costs receive support from the state. The remaining funding comes through contributions from individuals, at the point of need. Many informal carers also provide support for friends and relatives, and as such provide a high proportion of additional care and support.

Many people who have substantial or critical levels of need must pay for all or part of their care and support privately or rely on informal care. The poorest people who have substantial or critical need[39] are likely to receive state support. People with savings of more than £23,000 are not eligible for state funding for residential care or, in many areas, for home care.

Demographic changes mean that, by 2026, there will be twice as many people aged over 85, and four times as many aged over 100. In addition, medical advances mean that disabled people are living much longer lives. On the basis of official population projections and if disability rates remain broadly constant over time, we expect over 1.7 million additional people with care needs by 2026.

The PSSRU at the LSE has recently undertaken new modelling for the Government of the scale of demographic change, and the financial pressure that this represents for social care and other services for people with care and support needs. The modelling found that expenditure on care and support would need to rise substantially over the coming years:

- In order to just maintain the current system, costs would need to increase by upwards of 3.2 per cent (in addition to any extra costs of inflation) just to keep eligibility for services, and services themselves, the same as today.
- This would mean that, by 2026, 300,000 people with high needs would not receive the full hours of care that they need, i.e. they would have some of their need unmet.

Those people who are unable to get support via the state system would have to either try to fund it privately, look to their families to provide high levels of (potentially round-the-clock) unpaid care, or turn to the NHS, which could increase the costs to the state enormously. Furthermore, given that the care and support system is confusing and opaque, people will find it very difficult to prepare for the costs of their care and support in later life because they do not know what those costs are likely to be.

This is why reform of the way in which current resources are spent and of the overall funding system is required. This section will assess the impact of the proposal laid out within the Green Paper looking at options around:

a) making the best use of existing funding
b) bringing new money into the system
c) accommodation costs
d) a nationally or locally determined funding system.

[39] Fair Access to Care Services guidance on eligibility criteria for adult social care.

a) Making the best use of existing funding

Today's care and support system comprises a number of funding streams. The two largest sources of government funding for care and support are the social care system and disability benefits. Currently, the social care system only provides state-funded care and support for those people who meet a set, locally determined level of need and are eligible according to an assessment of their means. A substantial proportion of older people with support needs are outside this eligible group and either rely on disability benefits, informal care, go without support or spend considerable private funds on purchasing care services. In recent years, as a result of financial pressures, state-funded social care has been increasingly focused on individuals with the highest needs, with services withdrawn from people lower down the needs scale. Because of demographic changes, these financial pressures will increase and, without reform, increasingly large numbers of older people in need of support will not qualify for any state-funded social care assistance.

Drawing together other existing funding streams, such as certain disability benefits, into the overall care and support funding system could be one way of targeting resources at those most in need.

Options for reform

Option 1: Do nothing. In this case, existing funding streams would be left unreformed.	
Cost **Benefit**	There are no additional costs to maintaining the status quo.
Option 2: Integrating some disability benefits funding into the care and support system. We could look at drawing together some disability benefits for example, Attendance Allowance, with social care funding to provide a more joined-up, consistent and fair care and support system. If we were to do this it would be because it is our aim to create a new and better system, which would be simpler for all to use and access and focused on those most in need of support. Whatever the outcome of the consultation, we want to ensure that people receiving any of the relevant benefits at the time of reform would continue to receive an equivalent level of support and protection, under a new and better care and support system.	
Cost	• If there were benefit changes such as to Attendance Allowance, further detailed work on how the transitional arrangement and new funding system would be phased and implemented following the Green Paper would be needed. • As a result of transitional arrangements put in place, possible cost savings associated with drawing together funding streams would be released over time rather than instantly. But because this would be a significant reform, any new care and support system would also be phased in over a number of years. • There may be administrative costs associated with changing the delivery mechanisms by which care and support expenditure is delivered.
Benefit	• Drawing together some disability benefits, for example Attendance Allowance, within care and support would create a simplified, all-in-one assessment process for people with care needs. People would be able to access the support they need and their experience of the system would improve. • Better targeting of those most in need would lead to the most effective use of existing funding and it may also lead to potential cost savings
Winners and losers	• People receiving any of the relevant benefits at the time of reform would continue to receive an equivalent level of support and protection, under a new and better care and support system. • Some people – such as those with higher needs – who previously did not

	receive any state support would be better off, as targeting of support would mean that they would be entitled to some support under the new system (see the next section on bringing more money into the system). The exact impact on individuals will depend on the final design of the system.
Consideration	• Any changes to the care and support system in England would affect the devolved administrations in Scotland and Wales, if some disability benefits were to change; and Northern Ireland may also choose to adopt the new care and support system. • We will need to work closely with the devolved administrations to reach a shared view on how these changes provide the best possible outcomes for all people in the UK.

In developing the reformed system, further work will be needed to consider what funding streams could be integrated with the new care and support system, or aligned with it more closely to provide a better offer for individuals.

b) Bringing new money into the system

We have shown how the number of adults needing care in England is going to increase. The costs of care and support are going to increase rapidly, as are people's expectations, while the proportion of people who are working and paying income tax is going to fall as society ages. In this section, we describe the options that we have explored to build a simple, fair and affordable system for the future.

The options
Over the last year, the Government has looked at a whole range of ways in which care could be funded, on a continuum from completely privately funded to completely state funded.

The options we have looked at are as follows:

1) **PAY FOR YOURSELF**. In this system, everybody would be responsible for paying for their own basic care and support, when they needed it. They could take out insurance to cover some of these costs, or use their income and savings. There would be no support from the State even for people with the lowest incomes and no savings. This is ruled out because it would leave many people without the care and support they need, and is fundamentally unfair because people cannot predict what care and support they will need.

2) **PARTNERSHIP**. In this system, everyone who qualified for care and support would be entitled to have a set proportion - for example a quarter or a third – of their basic care and support costs paid for by the State. People who were less well off would have more care paid for – for example two thirds – while the least well-off people would continue to get all their care for free. The average cost of care for a 65 year old in their retirement is £30,000, so someone who got the basic offer of a third or a quarter paid for might need to pay around £20,000 or £22,500. Many people would pay much less. And some people who needed high levels of care and support would pay far more than this, and would need to spend their savings and the value of their homes. This system would work for people of all ages.

3) **INSURANCE**. In this system, everyone would be entitled to have a share of their care costs met, just as in the Partnership model. But this system would go further to help people cover the additional costs of their care and support through insurance, if they wanted to. The state could play different roles to enable this. It could work more closely with the private insurance market, so that people could receive a certain level of income

should they need care. Or the state could create its own insurance scheme. If people decided to pay into the scheme, they would get all their basic care and support free if they needed it.

People could pay in several different ways, before or after retirement or after their death if they preferred. As an indication of the costs, people might need to pay around £20,000-£25,000 to be protected under a scheme of this sort, compared with the average cost of care for a 65 year old in their retirement which is £30,000. This system would work for people over retirement age.

4) **COMPREHENSIVE**. In this system, everyone over retirement age who had the resources to do so would be required to pay into a State insurance scheme. Everyone who was able to pay would pay their contribution, and then everyone whose needs meant that they qualified for care and support would get all of their basic care and support for free when they needed it.

   It would be possible to vary how much people had to pay according to what they could afford. The size of people's contribution could be set according to what savings or assets they had, so that the system was more affordable for people who were less well off.

   Alternatively, if people wanted to be able to know exactly how much they would have to pay, most people other than those with lower levels of savings or assets could be required to pay a single, set figure, so that people knew how much they would have to save for.

   As an indication of the costs, people might need to pay around £17,000 - £20,000 to be protected under a scheme of this sort compared with the average cost of care for a 65 year old in their retirement which is £30,000. The cost would be less for people who were over 65 when the scheme was introduced. People could pay in several different ways, in instalments or as a lump sum, before or after retirement, or after their death if they preferred. Once people had paid their contribution they would get their care free when they needed it.

   We would also look at having a free care system for people of working age alongside this.

5) **TAX-FUNDED**. In this system, people would pay tax throughout their lives, which would be used to pay for all the people who currently need care. When, in turn, people needed care themselves, they would get all their basic care free. This system would work for people of all ages. This is ruled out because it places a heavy burden on people of working age.

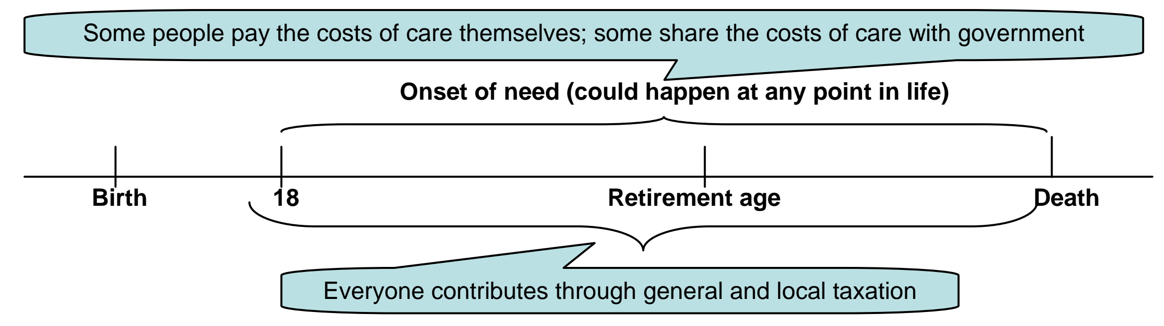
The costs and benefits of the options below show only the way in which the costs of basic care would be covered. All costs are presented in real terms and in 2006 prices. They are projections of likely costs based on a series of assumptions. They provide early indicative costs to compare relative funding options; these costs could alter substantially following decisions about precisely how the models would be implemented and based on overall public spending and prioritisation decisions. Costs would have to be met from within the public spending envelope set for future spending reviews, which will be in line with the plans for fiscal consolidation set out at Budget 2009. It should be noted that the costs have been estimated on the basis of national average data, and so are unlikely to fully reflect the variation in social, economic and demographic conditions in individual local authority areas.

However, the costs indicated are helpful as a point of comparison between the current system and the other options. There is more uncertainty around assumptions for younger adults and therefore fewer results are presented for this group. For instance, it is not possible to estimate

the amount of unmet need for younger adults or the amount that they may be expected to contribute towards their own care.

This section is only considering the cost of care packages (personal social services spend) and financial support (benefits) and not accommodation costs. This does not include the costs of care management or assessments. All of the costs outlined below are the overall costs (not the net additional costs.) For the purposes of the modelling, the PSSRU had to make some assumptions about the new system, so the costs shown are based on a system where Attendance Allowance had been drawn into care and support to create a new and better system, apart from the costs for the do nothing option, i.e. the current system. It should be noted that, depending on decisions about whether any disability benefits funding should be integrated or the extent to which other funding streams are drawn into care and support, the costs would vary.

THE CURRENT SYSTEM – DO NOTHING



In the current system, everybody pays in a limited contribution through general and local taxation, with state funding targeted at those who have highest needs and lowest means, rather than used to provide a 100 per cent state-funded system. The remaining funding comes through contributions from individuals and families, at the time they need care.

People with substantial and critical needs who have incomes or assets above certain thresholds must pay for all or part of their care privately or rely on informal care. The poorest people who have substantial or critical needs tend to get state support but, if someone enters residential care, they will have to contribute from their assets, including sometimes from the value of their home, unless they have only £13,500 worth of assets and they must give up all their income apart from £21.90 a week once they are receiving state care.

Our modelling suggests that the vast majority of younger people with mental health needs, physical disabilities and learning disabilities already receive full state support in the current system.[40]

In addition, people with care needs may be entitled to Attendance Allowance – a non-means tested, non-taxable disability benefit paid to the over 65s.

For the reasons specified earlier in this Impact Assessment (see 'Problems with the current system', page 9), this option has been ruled out.

Cost	• This option is projected to cost £17.3 billion to the state in 2014, rising to £23.6 billion in 2024 (this is for all adults). This is based on our modelling and assumptions and does not reflect any decisions on planned expenditure. • The point-of-need costs of care packages to older people in need of care are

[40] This may be underestimating, however, the number of people who fund themselves, due to the lack of available data.

	estimated to be £2.8 billion in 2014, rising to £5 billion in 2024. • Our modelling projects that, in 2014, there would be 200,000 older people with high needs receiving just under six hours a week less care than they needed. This rises to 300,000 people in 2024. This may have unspecified knock-on costs for the NHS. • These costs are merely presented for comparison purposes. This is the 'do nothing' option in this case.
Benefit	The benefits of all the other options are presented in comparison with this option.
Winners and losers	The winners and losers of all the other options are presented in comparison with this option.
Risks	The risks of all the other options are presented in comparison with this option.

PAY FOR YOURSELF – NO STATE INTERVENTION

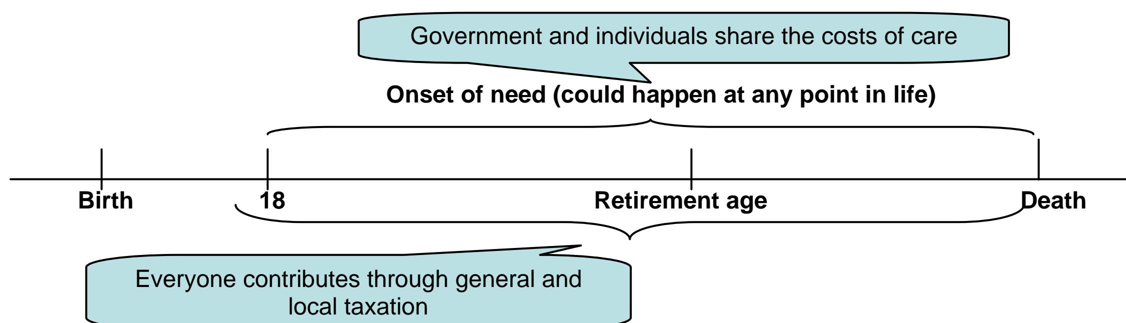
We looked at this option for older people. In this option, care and support would be considered predominately the responsibility of the individual with no intervention from the state. People could either:

- pay any care and support costs as required when a care and support need arises either out of their incomes or savings, or
- invest in private insurance to protect them against care and support costs in the future.

For the reasons mentioned below, this option has been ruled out.

Cost	• This option would be unaffordable for many people. Many people would not be able to afford the costs of private insurance. For those without insurance, the costs of care can be very high: someone who develops dementia could need 10 years of high-level, skilled care in a residential care home, which could carry a price tag of over £250,000. • Many people would be worse off than in the current system, as many people who couldn't afford insurance, or the costs of care should they arise, would now be left with no support from the state. • However, we would expect there would be additional costs to the NHS, as people develop high care needs, so the net saving would be less.
Benefit	The state would make substantial savings from withdrawing support. It would be clear to people that they were entitled to no support from the state, and would have to manage the risk of needing care themselves.
Winners and losers	This option would have a large negative impact on people on low incomes and with high levels of need, as the group of people who would previously have been eligible for state support and also who are unable to afford the costs of care or insurance themselves.
Risks	Those individuals unable to afford the cost of care would be left without the care they need. This could result in high levels of unmet need in the future, or pressure on friends/families to provide informal care.

PARTNERSHIP



In this option, the state plays a greater role in the cost of care and pays for a share of everybody's care costs. The amount of support from the state depends on a person's individual circumstances:

- If a person had a very low income and assets, for example if they were on pension credit, they may get all of their care costs paid for from the state from a relatively low level of need.
- If a person had a moderate income and assets, they may find that they are expected to pay for half of their care costs but that, as their needs become more severe, the level of state support increases until they too are having all their care costs paid by the state.
- Somebody on a very high income and assets may be expected to pay a larger share of their costs, but even the richest person would still be offered around a third/quarter of the costs of their care.

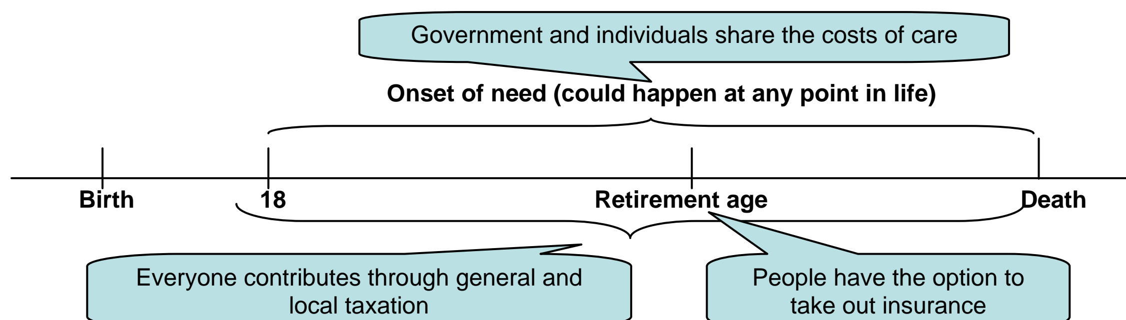
The amount of state support somebody gets therefore depends both on how great their need for care and support is, and on how much they can contribute themselves. Everybody would get a set proportion – for example, a quarter or third of their basic care and support paid for by the state.

We would expect the majority of younger adults to be entitled to full support because younger disabled people tend to have low incomes and assets.

Cost	• This option is estimated to cost the state £18.2 billion in 2014, rising to £22.5 billion in 2024 (for all adults). The costs of this option are sensitive to the number of years over which it is estimated and could vary accordingly. • The point-of-need costs to older people in need of care are estimated to be £1.4 billion in 2014, rising to £3.1 billion in 2024.
Benefit	• Our modelling projects that the number of high-need older people with unmet needs would fall in comparison with the current system. It estimates that, in 2014, there would be 150,000 older people with high needs receiving just under three hours a week less care than they needed, rising to 200,000 people in 2024. (This may have unspecified, though reduced, knock-on costs for the NHS.) • Very tentative estimates produced by the Department of Health suggest that the Partnership system could result in £200 million in savings for the NHS, as a result of the reduced unmet need. This draws on the PSSRU modelling of unmet need and is based on a range of options.

	• This option could also have a positive impact on carers, reducing the levels of care they need to provide.
Winners and losers	• People with moderate needs and people with high wealth, particularly those with savings over £23,000 who develop care needs, would gain from this system, as they would previously have not been eligible for state support. • Homeowners entering residential care would gain from this system, if they previously would have had their home included in the means-test and would thus be ineligible for state support. If their home would not have been included in the means-test, they would be no worse off under this system.
Risks	• Disability benefits are designed to meet broadly similar objectives to the social care system. If we did decide to integrate any disability benefit into a reformed care and support system we would want to ensure that the future care and support system retains and builds on the main advantages of the current disability benefits system. We also want to ensure that people receiving any of the affected benefits at the time of reform would continue to receive an equivalent level of support and protection. • The additional costs of this option for younger adults are relatively small. However, due to modelling limitations, there may be demand effects to having a more generous system which it has not been possible to take into account. Therefore, the costs may be higher than estimated.

INSURANCE (PRIVATE)

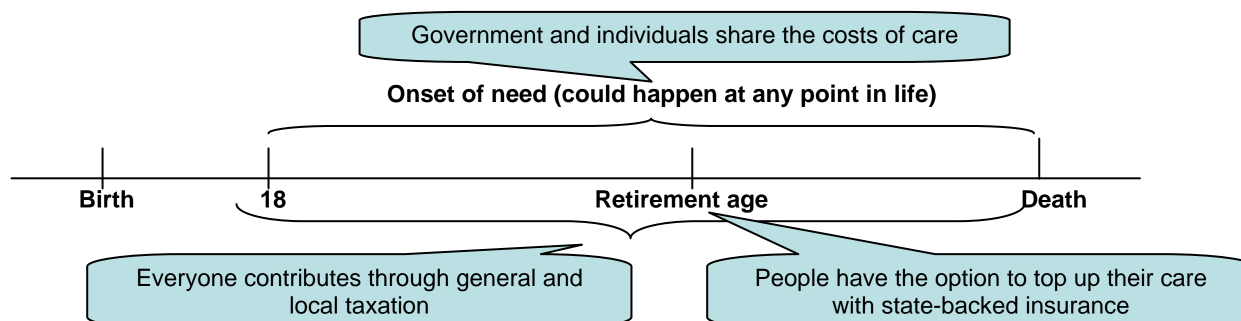


In this model, everyone who is assessed as having a care need would be entitled to have a share of their care costs paid, just as in the Partnership model. In addition, older people could choose to insure themselves against the difference between what they might expect to receive from the state and how much care may cost. With the state offering to pay a set proportion, for example a quarter or a third of everybody's care costs, insurance premiums could be much lower than they are currently. We would need to work with the insurance industry to develop a framework for simple and standardised insurance products.

Cost	• This option is estimated to cost the state £18.2 billion in 2014, rising to £22.5 billion in 2024 (for all adults). • The point-of-need costs of care packages to older people in need of care are estimated to be £1.4 billion in 2014, rising to £3.1 billion in 2024. Some of the costs could be met by individuals insuring themselves. • We cannot estimate what the costs of premiums would be and it would be a matter for the market to determine.
Benefit	• This options would have the same benefits as the Partnership model stated above • The additional benefits would depend on how many people purchase

	insurance. We estimate fewer than10% of people will opt into the system, and will enable those who can afford to buy the insurance to protect their inheritance if they develop a care need. Those who insured themselves would have peace of mind that some of their inheritance would be protected against the costs of care. • This option could also have a positive impact on carers, reducing the levels of care they provide.
Winners and losers	• People with moderate needs and people with high wealth, particularly those with savings over £23,000 who develop care needs, would gain from this system, as they would previously have not been eligible for state support. • Homeowners entering residential care would gain from this system, if they previously would have had their home included in the means-test and thus be ineligible for state support. If their home would not have been included in the means-test, they would be no worse off under this system. • Winners will be those who have insured themselves and the cost of their care excluding the state guarantee is more than the value of their insurance premium. • Losers will be those who purchase insurance and do not develop a care need, but this does not consider the benefit of their peace of mind from knowing that they were insured.
Risks	• Disability benefits are designed to meet broadly similar objectives to the social care system. If we did decide to integrate any disability benefit into a reformed care and support system we would want to ensure that the future care and support system retains and builds on the main advantages of the current disability benefits system. We also want to ensure that people receiving any of the affected benefits at the time of reform would continue to receive an equivalent level of support and protection. • The additional costs of this option for younger adults are relatively small. However, due to modelling limitations, there may be demand effects due to having a more generous system, which it has not been possible to take into account. Therefore, the costs may be higher than estimated. • This assumes it is possible to develop an attractive insurance product that offers value for money.

INSURANCE (STATE-BACKED VOLUNTARY INSURANCE)

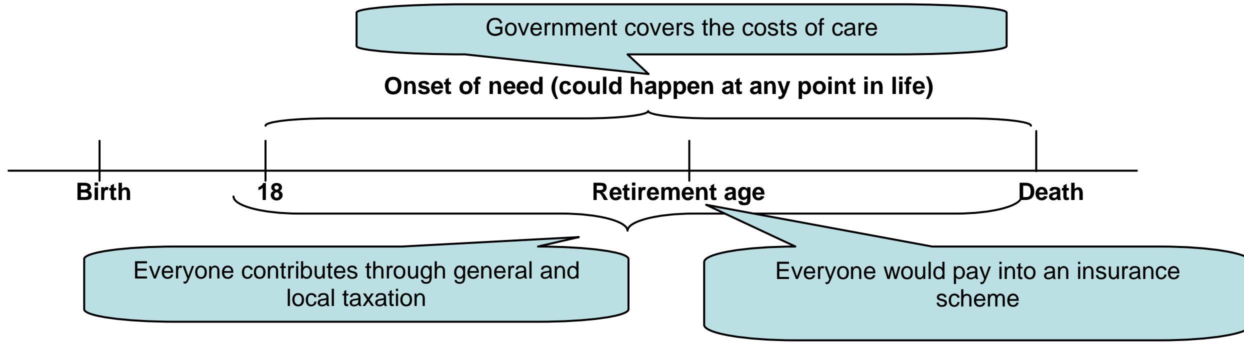


In this model, everyone who is assessed as having a care need would be entitled to have a share of their care costs paid, just as in the Partnership model. Again, people who are less well-off or have higher care needs would have more of their care paid for. But, in addition, the Government would help people to prepare to meet the costs of the contributions that they would have to pay for themselves, through a state-backed insurance-based approach.

This option has not been modelled.

Cost	• This option is estimated to cost the state at least £18.2 billion in 2014, rising to £22.5 billion in 2024 (for all adults). • This option might cover 20 per cent of people. As an indication of the costs, people might need to pay around £20,000 - £25,000 to be protected under a scheme of this sort. However, further research would be needed and the exact level of the premium would depend on the exact design of the system, and on future decisions about central government investment in care and support as well who opted into the system. • The premium would need to be high enough to cover the additional administrative costs associated with this system. These costs have not been estimated.
Benefit	• This option has not been modelled in detail but this would have the same benefits as the Partnership model. • The additional benefits would depend on how many people purchase insurance. This insurance might cover 20 per cent of people and enable the best-off to buy a premium that protects their inheritance if they develop a care need. • Those who insured themselves would have peace of mind that some of their inheritance would be protected against the costs of care. • This option could also have a positive impact on carers, reducing the levels of care they provide.
Winners and losers	• People with moderate needs and people with high wealth, particularly those with savings over £23,000 who develop care needs, would gain from this system, as they would previously have not been eligible for state support. • Homeowners entering residential care would gain from this system, if they previously would have had their home included in the means-test and thus be ineligible for state support. If their home would not have been included in the means-test, they would have been no worse off under this system. • Winners will be those who have insured themselves and the cost of their care excluding the state guarantee is more than the value of their insurance premium. • Losers will be those who purchase insurance and do not develop a care need but this does not consider the benefit of their peace of mind from knowing that they were insured against 100 per cent of their care costs. • In a voluntary system, poorer people purchasing insurance in this system would be over-paying for their free care, because they would already be entitled to more than the minimum contribution from the state.
Risks	• Disability benefits are designed to meet broadly similar objectives to the social care system. If we did decide to integrate any disability benefit into a reformed care and support system we would want to ensure that the future care and support system retains and builds on the main advantages of the current disability benefits system. We also want to ensure that people receiving any of the affected benefits at the time of reform would continue to receive an equivalent level of support and protection. • The additional costs of this option for younger adults are relatively small. However, due to modelling limitations, there may be demand effects to having a more generous system which it has not been possible to take into account. Therefore, the costs may be higher than estimated.

COMPREHENSIVE



Under this option, everyone over retirement age who had the resources to do so would be required to pay into an insurance scheme. People would pay their contribution and then everyone over retirement age would get all of their care for free when they needed it. The amount that people would have to pay could either be set at a single figure so that people over retirement age paid the same, or it could be tailored so that less well-off people paid less. There would be a number of methods by which people could choose to pay into the system.

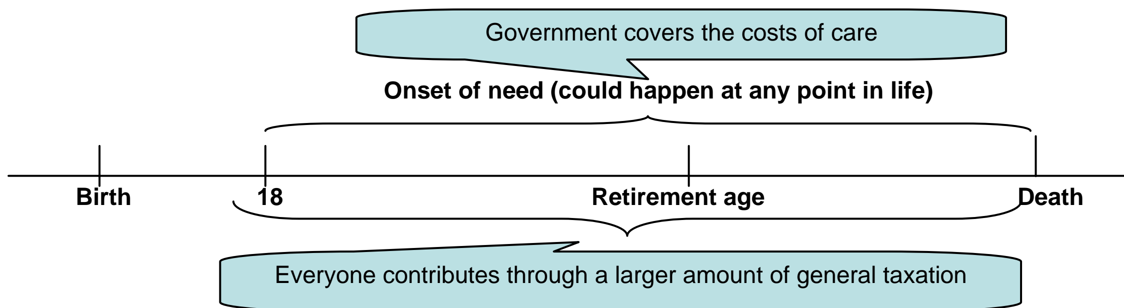
Cost	• This option is estimated to cost the state £20.7 billion in 2014, rising to £27.4 billion in 2024 (for all adults).[41] • This includes the costs to people paying extra into the insurance scheme. As an indication of the costs, people might need to pay around £17,000 - £20,000. The exact level of the premium would depend on the exact design of the system, and on future decisions about central government investment in care and support • There will be additional costs to administer the scheme. These are dependent on how the scheme is set up. They have not been quantified.
Benefit	• Our modelling projects that the number of older people with unmet need would fall in comparison with the current system. With all the basic care costs of people with high need levels covered by the insurance, we would expect no unmet need for older people in this group. • This option could also have a positive impact on carers, reducing the levels of care they provide. • The system will be simpler to understand, especially given that there will be no means-test, which should improve overall user experience.
Winners and losers	• People with moderate needs and people with high wealth, particularly those with savings over £23,000 who develop care needs, would gain from this system, as they would previously have not been eligible for state support. • Homeowners entering residential care would gain from this system, as they're now eligible for full state support. • Winners will be those who whose cost of their care excluding the state guarantee is more than the value of their insurance premium. • Losers will be those who do not develop a care and support need but this does not consider the benefit of their peace of mind from knowing that they were insured against 100 per cent of their care costs.
Risks	• Disability benefits are designed to meet broadly similar objectives to the social

[41] We have proxied the costs of this model by looking at the costs of the tax-funded model because care is free at the point of need in both models. Therefore, the costs stated here are estimates and could vary. The costs do not take account of the changes in State Pension retirement age.

	care system. If we did decide to integrate any disability benefit into a reformed care and support system we would want to ensure that the future care and support system retains and builds on the main advantages of the current disability benefits system. We also want to ensure that people receiving any of the affected benefits at the time of reform would continue to receive an equivalent level of support and protection. • The additional costs of this option for younger adults are relatively small. However, due to modelling limitations, there may be demand effects to having a more generous system which it has not been possible to take into account. Therefore, the costs may be higher than estimated.

TAX-FUNDED

Under this option, everyone in society would contribute to the costs of care through increases in general taxation of approximately £3.4 billion in 2014, rising to £3.8 billion in 2024. In return, they would get all of their basic care costs paid by the state.



For the reasons mentioned below, this option has been ruled out.

Cost	• This option is estimated to cost the state £20.7 billion in 2014, rising to £27.4 billion in 2024 (for all adults). • The costs to people paying through general taxation is estimated to be around an additional £3.4 billion a year, rising to £3.8 billion by 2024. This would place a large burden on people of working age.
Benefit	• Our modelling projects that the number of older people with unmet need would fall in comparison with the current system. With all the basic care costs of people with high need levels paid for by the state, we would expect no unmet need for older people in this group. • This option could also have a positive impact on carers, reducing the levels of care they provide. • The system will be simpler to understand, especially given that there will be no means-test, which should improve overall user experience.
Winners and losers	• People with moderate and high incomes, particularly those with savings over £23,000 who develop care needs, would gain from this system, as they would previously have not been eligible for state support. • Homeowners entering residential care would gain from this system, as they would now be eligible for full state support. • There would also be winners and losers within the taxation system. With more tax needing to be raised, we would expect losers, but further work would need to be conducted to consider the impact on different groups. However, it is likely that this would place a large burden on people of working age. We would also expect losers to be those without a care need.

	• People with higher incomes/assets requiring care would win during the years they require care, albeit they may have contributed more in taxation earlier in their lives.
Risks	• The number of adults of working age is falling in comparison with the number of people over retirement age. As this dependency ratio continues to change, there is a risk that relying on general taxation may become less sustainable. • Disability benefits are designed to meet broadly similar objectives to the social care system. If we did decide to integrate any disability benefit into a reformed care and support system we would want to ensure that the future care and support system retains and builds on the main advantages of the current disability benefits system. We also want to ensure that people receiving any of the affected benefits at the time of reform would continue to receive an equivalent level of support and protection. • The additional costs of this option for younger adults are relatively small. However, due to modelling limitations, there may be demand effects to having a more generous system which it has not been possible to take into account. Therefore, the costs may be higher than estimated.

Summary of the costs of all options[42]
The costs summarised below are the costs of care packages, i.e. the costs at the point of somebody needing care. It is important to note that the costs to people of paying into an insurance scheme or administrative costs are not included in this table and the costs of status quo refers only to social care expenditure.

They are projections of likely costs based on a series of assumptions. They provide early indicative costs to compare relative funding options; these costs could alter substantially following decisions about precisely how the models would be implemented and based on overall public spending and prioritisation decisions. Costs would have to be met from within the public spending envelope set for future spending reviews, which will be in line with the plans for fiscal consolidation set out at Budget 2009.

	Cost of care to the state (for older people) (£bn)		Cost of care to the state (for younger adults) (£bn)		Cost of care packages to older people with care needs (£bn)	
	2014	2024	2014	2024	2014	2024
Pay your own	This option was not modelled, because it has so many other negative outcomes in terms of affordability and equality of outcomes for people with different incomes.					
The current system	12.3	16.8	5	6.8	2.8	5.0
Partnership	13.1	15.6	5.1	6.9	1.4	3.1
Insurance (Private)	13.1	15.6	5.1	6.9	1.4	3.1
Insurance (state – backed)	This option has not been modelled.					
Comprehensive	15.6	20.5	5.1	6.9	0	0
Tax-funded	15.6	20.5	5.1	6.9	0	0

Cost in comparison with the status quo, the current system.

[42] All costs are presented in 2006 prices.

	Cost to the state for older people (£bn)		Cost to the state for younger adults (£bn)		Cost of the system to older people (£bn)	
	2014	2024	2014	2024	2014	2024
Pay your own	N/A					
The current system	0	0	0	0	0	0
Partnership	0.8	-1.2	0.1	0.1	-1.4	-1.9
Insurance (private)	0.8	-1.2	0.1	0.1	-1.4	-1.9
Insurance (state-backed)	This option has not been modelled.					
Comprehensive	3.3	3.7	0.1	0.1	-2.8	-5
Tax-funded	3.3	3.7	0.1	0.1	-2.8	-5

Options ruled out
There are costs and benefits to all the options, and there is no clear 'right' option. However, we do not believe that merely continuing with the current system is an option. It is not effective for users and not financially sustainable to maintain current patterns of care in that public expenditure would need to rise faster than national income.

We do believe that the state has a role to play in supporting people with the costs of care and support, and therefore we do not think a system which relies solely on people paying for themselves is feasible. In terms of equity, if no state funding were available, many people would not be able to afford to buy the care they need. One estimate[43] suggests that around 2.6 million people do not have financial resources sufficient to support them for more than a year of long-term care, even when taking into account all their income, savings and housing assets. As a result of the potentially high costs of care and support, and of market failures, currently or potentially available financial products do not offer solutions for people with low or moderate levels of income and assets. This would result in unmet need, likely to result in poor quality of life or early morbidity, alongside huge burdens for informal carers.

We have ruled out options that rely predominantly on general taxation, i.e. tax funded, because we believe this would be unfair and unsustainable.

- The burden on working age individuals will increase – there are four working age people for every one retiree now, but by 2050 there will only be two working age people for every retiree.[44]
- This would give older people far more than the system that they paid into.
- Not everyone over retirement is well off but we know that many pensioners are on low incomes and require support in meeting the costs of care and support. However, we know some pensioners are wealthier. In 2004, people over retirement age collectively held £932 billion in housing assets have benefited more from the long-term increase in house prices above rates of inflation.[45] By contrast, a large of proportion of people of working age people who will make a substantial contribution to these have struggled to get onto the property ladder due to rising house prices, and often pay higher mortgages.

We therefore believe that the most viable options are Partnership, Insurance and Comprehensive.

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[43] See Table 4 in Mayhew I (2009) *The Market Potential for Privately Financed Long Term Care Products in the UK*. Cass Business School Actuarial Research Reports.
[44] Pensions Commission (2004) *Pensions: Challenges and Choices*, citing Government Actuary's Department, 2002 projections.
[45] International Longevity Centre/Lloyd J (2008) *A National Care Fund for long-term care*.

c) Accommodation costs

In a new funding system, care costs and accommodation costs may be considered separately, with the state playing a larger role in meeting the cost of care. If the state takes more responsibility for care costs, then the average amount spent by people not entitled to means-tested support for accommodation costs will fall.

When a person needs care in a residential home, they not only face the costs of care. There are also associated charges, such as the costs of maintaining the room, providing food and doing laundry. These 'accommodation costs' are a normal part of everybody's life, regardless of whether they have a care need or not.

Although there will always be a role for the state to play in helping people with low income and assets, we believe it is fair to expect the majority of people to cover these costs.

Current situation and challenges/problems faced
When people first enter residential care, local authorities disregard the value of their home for the first 12 weeks of their stay. After this time, the value of the property may be taken into consideration when assessing a person's means, and thus their entitlement to local authority support. The value of the home could still be disregarded if it is occupied by:

- the resident's partner, or former partner (except where the resident is estranged or divorced from the partner/former partner)
- a lone parent who is the claimant's estranged or divorced partner
- a relative of the resident or member of his family who is:
    - aged 60 or over
    - aged under 16 and is a child whom the resident is liable to maintain
    - incapacitated.

Since 2001, local authorities have had discretionary powers to make a deferred payments agreement with residents. Under such an agreement, the local authority places a charge against the value of the property, which is not collected until the end of the contract (this is usually when the resident dies). A deferral may give a family more options about how to pay a charge which has accrued. For example, the debt may be small enough that remortgaging the house or a loan may cover the debt and the property need not be sold.

Options for reform considered

Option 1: Do nothing. This option would mean continuing with the current system. The majority of local authorities already offer deferred payments schemes	
Cost	By definition, there are no costs or benefits associated with this option.
Benefit	

Option 2: Compulsory deferred payment scheme. At present, local authorities that choose to can offer individuals to pay for their care through a deferred payments scheme. However, this option is not currently available to all – approximately 30 local authorities do not offer deferred payments to people entering residential care.[46] We propose making the scheme available to all who wish to use it. We will need to consider whether the scheme will charge interest on deferred payments offered.	
Cost	• It is difficult to estimate the cost of making such a scheme compulsory. Up to 20 per cent of local authorities do not offer deferred payments. If it is assumed

[46] Local authority estimates.

	that this translates into 20 per cent of care home places that are privately funded each year, this involves 7,000 to 9,000 residents not being offered deferred payments. If, for example, 5 per cent to 10 per cent of these admissions (this is in line with the experience of other local authorities) were to take up such an agreement, this means that around 350 to 900 people a year would want to take up such an agreement and currently are not being offered it. If interest is charged on all payments, there would be no net additional costs in that all these would be covered by the interest charged. • There would be some administration costs but further work is needed to quantify these. • Local authorities will need resources from which to make the loans. • It should noted that there would be some opportunity costs for local authorities, with funding tied up to cover deferred payments – particularly at the start of the scheme before deferred payments started to come in.
Benefit	Benefits for a compulsory deferred payments scheme are likely to have a positive impact on people needing care and their families, as the transition into a care home would become less stressful if the house did not also have to be sold at the same time. There is also the problem that it can take time to sell the home, in which case the payments need to be made from elsewhere.
Consideration	Work would need to be undertaken to consider whether this scheme would be delivered locally or nationally.
Risk	There is a risk that individuals will default on payment, i.e. avoid repayment which will incur additional cost to the state.

d) A nationally or locally determined funding system

Current situation and challenges/problems faced
The current funding system gives local authorities considerable discretion about the amount of money they spend on social care, through local decisions on eligibility and the amount raised locally through council tax. This system has contributed to:

- a lack of transparency in the system
- unfairness in the system.

Lack of transparency in the system
Many people have told us that they do not know what financial support they may be eligible for or entitled to. People do not know that they could be responsible for paying for so much of their own care, and so they do not properly prepare for the costs involved.

People also don’t understand why some people get care funded by the state and others don’t. Although some local authorities do make their criteria public, it is not always clear why different local authorities make different decisions about people with similar needs.

Unfairness in the system
Many people have told us that the current system seems unfair to them. They are particularly worried that people who have worked hard and saved do not get state support, while people who have never saved may get their care for free.

Local authorities use the FACS system to assess and determine eligibility for services, to try to make such decisions more transparent. Of course, there are many ways in which local authorities support people with low or moderate care needs, including housing or leisure

programmes, but knowing that a neighbouring local authority is supporting the cost of care packages for people with lower levels of need can also contribute to a feeling of unfairness.

Options considered (including cost/benefit implications)

Option 1:Do nothing. Continue with the current system of local determination of eligibility and level of support.	
Cost	By definition, there are no costs or benefits associated with this option.
Benefit	

Option 2: National consistency with some local flexibility. Under this system, there would again be nationally transferable (portable) assessments. Central government would set the threshold for which someone was eligible for state support. Therefore, if a person has a certain level of need, they will be eligible to receive funding to meet their care and support costs. However, local authorities would still decide for themselves the monetary amount of care and support they were going to provide at each level of need.	
Cost	• There would be costs associated with moving towards a more consistent system in order to remove variability in the current system. We would need to do more work to quantify this policy as it develops but, for example, if we introduced any of the Partnership funding options for older people, this would create: o a new burden imposed by a more generous offer from central government, possibly as much as £1.3 billion in the first year. This new burden would need to be fully funded, to avoid increasing pressure on council tax • Funding levels will depend on how much money your local authority wants to spend on care and support; therefore, help will vary depending on where you live, meaning cash entitlements would not be portable across local authority boundaries. • Central government would also need to enforce a minimum cash amount of funding given for a particular need level to ensure that basic needs are still met. • We would need to do more work to quantify this policy as it develops.
Benefit	• Local authorities would still decide for themselves what level of support they were going to provide at each level of need. This would enable local authorities to control their own care and support budgets. • Enables people to know, before they move somewhere, what level of support they would be entitled to in the new area. • Allows local authorities to cater for variation in the local care market and more accurately cater for individuals' needs.

Option 3: Make the allocation of resources standard across England. Under this system, there would again be nationally transferable (portable) assessments. However, the difference would be that people who received an assessment at a particular level would then be entitled to a nationally determined level of support. We could set up a system where everyone who had the same level of need received exactly the same funding wherever they lived in England, but this wouldn't take account of the fact that the same amount of money will buy fewer services in one area of England as compared to another. Or we could have a national system that gave people slightly different amounts depending on where they lived in England to take account of the different costs of care across England.	
Cost	• Central government would not be able to as accurately take account of the

	variations in local care markets and individuals' needs as if the amount were determined locally. • There would be individual winners and losers due to the variation. Transitional protection would be required for the losers. This cost has not been quantified • We would need a new organisation to administer payments to individuals. • We would need to do more work to quantify this policy as it develops.
Benefit	• A simpler system that can be more readily presented and explained to potential beneficiaries who will be encouraged to plan more. • Everyone with the same care and support needs will get the same level of help. • Portability between localities giving citizens more opportunity to move and more certainty about the support they will receive. • Would create savings for local authorities as they would no longer need to manage care and support budgets.
Risks	• Having a single, fully national system in England would mean major changes to the way that local authorities raise and spend funding for care and support. • At the moment, local authorities use funding that they get from central government to pay for the care they provide. In addition, they can decide to fund additional demand on their local services, by using funding from council tax over and above the funding they receive from central government. • If national government, rather than local authorities, were deciding how much funding people should get, it would be unfair to ask Local Authorities to fund this new system from money they raised themselves, as they would have no way of controlling these costs. • Under a national system, then, it is likely that all funding for social care would need to be raised nationally, instead of some of it coming through council tax. • In aggregate, government would not have the necessary incentives or levers to drive value for money and efficiency in regard to social care.

Specific impact tests: checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

Ensure that the results of any tests that impact on the cost/benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	Results in evidence base?	Results annexed?
Competition assessment	No	Yes
Small firms impact test	No	Yes
Legal aid	n/a	n/a
Sustainable development	n/a	n/a
Carbon assessment	n/a	n/a
Other environment	n/a	n/a
Health Impact Assessment	Considered as part of this Impact Assessment	Considered as part of this Impact Assessment
Race equality	No	Separate document
Disability equality	No	Separate document
Gender equality	No	Separate document
Human rights	No	Separate document
Rural proofing	No	Separate document

Competition Assessment

1) In any affected market, would the proposal directly limit the number or range of suppliers?

No. No direct impacts on the number or range of suppliers is anticipated from any of the proposals.

2) In any affected market, would the proposal indirectly limit the number or range of suppliers?

No. None of the proposals are anticipated to limit number or range of suppliers. Indeed, the continued roll-out of individual budgets as part of the ongoing transformation of social care and some of the new proposals under consideration – for example, the additional information for providers proposed – could aid market entry, thereby increasing the number or range of suppliers.

3) In any affected market, would the proposal limit the ability of suppliers to compete?

Possibly. The option for government to run a voluntary insurance scheme could potentially limit the ability of current or potential private sector suppliers of insurance to compete. This is because a state-backed insurance system could be seen by consumers to be backed up by taxpayers' money and therefore more reliable than private sector insurance products. It is more likely that there would be an effect on competition if a state-backed insurance system were to be subsidised by taxpayers' money; the impact would be likely to be less if the state-backed insurance system were free-standing and not reliant on subsidy. However, the exact impact on competition would depend on the detailed design of the reforms and, as these are at an early stage, they cannot yet be quantified.

The proposal would not limit the ability of suppliers of care services to compete.

4) In any affected market, would the proposal reduce suppliers' incentives to compete vigorously?

No. Overall, it is likely that the proposals set out for consideration in the Green Paper would serve to improve competition through the market development activities that could increase the range and number of suppliers, as well as additional support to people who are in need of care and support, which could potentially help them to be better-informed consumers within this market. It is not possible at this early stage to quantify the potential benefits of this impact. Substantial work to understand in more detail any potential effects on competition from the options set out in the Green Paper will be required before any of the proposals are finalised.

Small firms impact test

Does the regulation apply to small businesses or affect the business environment in which they operate?

Small business plays a crucial role in the provision of care and support. Over two-thirds of services are provided by private businesses and voluntary organisations. Over half the care homes in England are small, often family-run businesses, and the great majority of home care is provided by small local businesses. The total value of care and support in 2007/08 was just under £22 billion, of which £16.5 billion was spent by local councils. Some 1.75 million people

used care and support and there were 18,500 care homes, 4,900 home care agencies and 1.5 million people employed in providing care and support. Fifty-four per cent of expenditure went to residential care homes costing an average of £24,000 per person per year. Forty-six per cent of expenditure went to home-based services at an average cost of £6,500 per person per year.[47]

While there is a growing need for care across England, and there will continue to be increasing demands for care and support services, the current pattern of services has been stable for a number of years. Care homes operate at an average occupancy of 90 per cent.[48] However, the level of funding for services, the range of services available and the prices paid for services vary greatly from one part of the country to another. For example, Torbay has 74.6 care home places per 1,000 population aged over 65 while Westminster has just 12.1.[49] A nursing home place in the home counties north of London costs on average £815 per week, while the same service in Northern Ireland costs £517 per week.[50]

The Putting People First programme to transform social care is giving individuals more choice and control over the services they receive. Early indications from the first year are that already nearly 100,000 people have a personal budget and that one in five people who receive support at home now have a personal budget. Accelerating progress over the next two years should see the majority of people who receive support at home enjoying the greater control offered by a personal budget.

The Green Paper discusses the importance of making the market work better for people, so that people are supported to choose from a wider range of better-quality care and support services, and points to the role for local authorities in market-making. This role is not new and is already a responsibility for local authorities. The Green Paper sets out proposals to improve the information and advice available for people.

The Green Paper also sets out some ways in which local government could support providers to offer the services that people want, for example through making information available to providers or potential providers, and sets out the actions that some local authorities are taking. It seeks views on how to remove the barriers to giving people choice around the care and support they get, and ensuring that the care and support provided is high quality.

If taken forward, any such proposals would have an impact on small business, because small businesses play such a key role in the provision of care and support services. The intention of any such proposals would be to have a positive impact on the market for care and support services, including those services provided by small businesses. No proposals that would add to the regulatory burden on small firms are under consideration in the Green Paper.

The Green Paper is seeking views on all proposals that would have an impact on small firms and government would welcome views from small firms on what steps they feel local or central government could take to support the better functioning of the market for care and support. The proposals are currently at an early stage and significant additional work would be required in terms of developing the proposals in the light of the consultation responses and understanding their potential impact on the market in general and on small firms in particular, before their impact can be quantified.

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[47] Commission for Social Care Inspection (2009) *The State of Social Care 2007/08*.
[48] Laing and Buisson (2007) *Care of Elderly People Market Survey 2007.*
[49] Commission for Social Care Inspection (2009) *The State of Social Care 2007/08.*
[50] Laing and Buisoon (2007) *Care of Elderly People Market Survey 2007.*

Annex A: The inadequacy of purely private solutions

The cost of care can be very expensive, especially if care is required for long periods. There is also uncertainty around the estimates of how many people will need care and for how long. Together, these issues mean that pre-funded insurance to cover the costs of care is too expensive for people on low or moderate incomes. This is the only product that offers a degree of risk-pooling between those who need care and those who do not. This means that purely private solutions, with no state contribution to the costs of care, can be ruled out on the grounds of equity and would not meet the Government's vision for a new care and support system.

Market-based financial products cannot offer solutions for people with low or moderate levels of income and assets:

- Private pre-funded care insurance is too expensive for people on low or moderate incomes, and the market has effectively collapsed. Half of pensioner households have an annual income of less than £10,400 a year and a premium that would meet the cost of a care home if needed costs at least 9–22 per cent of that income for each person.[51]
- Due to the compound interest charged by equity release companies, a loan of £35,000 to buy care insurance at age 65 will grow to over £100,000 by age 85, which is well over the average costs of care.[52]
- Once in need of care, people could release equity to buy immediate needs annuities to cap some of their losses but these are expensive since the risk of needing care is not pooled.
- One innovative proposal is for disability-linked annuities.[53] Of the 50 per cent of people who have private pensions, most are of inadequate size to help with the costs of care and support – if used to buy a disability-linked annuity, an average pension 'pot' of £24,000 would buy about £3,000 a year of income for a person with severe disability.[54] This is not enough to pay for the costs of care.

The lack of financial products is caused by several market failures, as well as lack of affordability for lower income groups. These include:

- demand-side problems, with people underestimating the risk that they will need long-term care in the future, having poor knowledge about their responsibilities or the potential costs, and a behavioural tendency to put off and undervalue the importance of decisions now that relate to future wellbeing[55]
- supply-side problems, particularly around predicting risk.

Some of these mechanisms for releasing finance could, however, be helpful as part of a state-backed funding system.

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[51] Male and female sample premiums for 'Care Prepared' plan, provided to the Department of Health by Partnership Life Assurance Company Ltd, unpublished.
[52] Mayhew L (2009) *The Market Potential for Privately Financed Long-Term Care Products in the UK*. Cass Business School Actuarial Research Reports.
[53] A disability-linked annuity suppresses annual pension income until a care need develops, when a higher income is payable.
[54] Mayhew L (2009) *The Market Potential for Privately Financed Long-Term Care Products in the UK*. Cass Business School Actuarial Research Reports.
[55] See, for example, Cabinet Office (2008) *Achieving Culture Change: A Policy Framework*.

Annex B: Prevention

1) Introduction to prevention

Prevention is about achieving better outcomes for people and improving cost-effectiveness through reducing demand for care and support. Defining prevention is complicated. It can include avoiding dependency, targeted rehabilitation and recuperation as well as broader approaches to improving the quality of life. There are three general levels of prevention.[56]

Primary prevention
The first level is concerned with supporting people to remain independent and promoting good health and wellbeing. Interventions include making information about universal services and how to stay healthy available for all, and raising awareness of public health messages. Scientific research aimed at finding ways to reduce the prevalence of diseases that are associated with care and support needs – for example, dementia, chronic obstructive pulmonary disease and arthritis – also counts as preventative activity. Many preventative interventions are already carried out by the NHS and by local authorities, and are funded by the Government. The Change4Life campaign to counter obesity is targeting young families, encouraging them to eat better and move more. At local level, the Partnership for Older People Projects (POPPs) have put in place a range of services and approaches to prevention, with an evaluation to be published in autumn 2009.

Secondary prevention
The second level of prevention is identifying those at risk of specific conditions or events which would have a negative impact on their wellbeing, and slowing any deterioration. This includes working with people who have existing low-level needs to improve their situation and minimise avoidable risks or escalation of need. Examples of the kinds of interventions or services relevant here include telecare, supported housing, falls prevention programmes and minimising risk factors for stroke in people diagnosed with related health problems. Many national health programmes fall into this category, targeting interventions at particular 'at-risk' groups, such as flu vaccination (for vulnerable groups, including all over-65s), vascular checks (for 40 to 75-year-olds) and breast cancer screening (for women aged 50–70).

Tertiary prevention
Tertiary prevention includes reducing disability or deterioration from established health conditions. This might cover rehabilitation or re-ablement services and joined-up packages to manage complex needs. Expert patient programmes could fall into this category, as could the national network of memory clinics for people diagnosed with dementia, for which funding was announced in the recent dementia strategy.

While the three-fold categorisation of preventative interventions is a useful analytical framework, it is important to remember that services at all three levels are needed – it is not a framework for prioritisation. In particular, individuals with complex needs will also require many of the 'lower-level' interventions as part of the support they receive. (Unfortunately, in some areas, these services are being limited because of the misconception that they are required only by people with a lower needs assessment.)

Some Department of Health programmes cut across the three types of prevention. For example, the prevention package for older people announced in 2008 sets out entitlements including flu vaccines, a range of screening programmes, support for foot care and reducing waits for audiology treatment and hearing aids. Similarly, the forthcoming ageing strategy will provide guidance to primary care trusts on commissioning these services, and will highlight new areas where prevention can help, for example in incontinence, arthritis and depression.

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[56] Department of Health (2008) *Making a Strategic Shift Towards Prevention and Early Intervention*.

2) Navigation and information

The difficulties of navigating the care system and the lack of information and advice were recurring themes in responses from stakeholders to the care and support engagement. While these are, by their nature, retrospective and do not take into account changes that local authorities are already planning, the responses – given to the Department of Health late in 2008 – are indicative of ongoing issues in the system. A few examples are given below.

Selected responses to the care and support engagement process

"Older people and their carers are left baffled by the care system with six out of ten (61.22 per cent) people complaining about a lack of information – particularly in relation to council care services.… There should be a first stop care advice service provided at a national level alongside independent information, advice and advocacy available at a local level."
Council and Care

"*Cutting the cake fairly*… drew on the experience of over 3,000 stakeholders, including people who use services and family carers. The main concerns [included] a lack of transparency and fairness; [and] a lack of information about services that might be available."
Commission for Social Care Inspection (CSCI)

"Free information, advice, advocacy and brokerage are needed regardless of means. Local and national government must do more to meet advice needs. Issues that most concerned people [included] the system is baffling with no information available when it's needed."
Age Concern

"Thirty-seven per cent of carers in one of our surveys had spent five years or more without the right benefits and 46 per cent without the right services, because they did not have the right information and advice about them.[57] The entry point to the system needs reform and we have set out proposals in our evidence."
Carers UK

3) The current evidence base

Some preventative interventions may reduce need, some may promote health or wellbeing, and some may do both. It is important to distinguish between those interventions that have been shown to reduce need or dependence on services, and those that have been shown to improve people's wellbeing but, as yet, have no evident impact on need.

Unfortunately, robust evidence that examines the effectiveness or cost-effectiveness of interventions is limited, and there is a need to carry out further research. Derek Wanless found in *Securing Good Care for Older People* (2006) that "there is an urgent need to establish the cost-effectiveness of prevention and preventative services. There appears to be significant promise in this regard, but the evidence base is not yet sufficiently developed."

There are, moreover, dangers in relying on 'common sense'; a study in Canada[58] found that older people receiving low-level home care were at a 50 per cent higher risk of both death and loss of independence than those not receiving the service.

[57] Carers UK (2005) *In the Know: the importance of information for carers*.
[58] Saskatchewan Health (2000) *The Impact of Preventative Home Care and Seniors Housing on Health Outcomes*.

The challenges of gathering evidence on prevention
The nature of preventative interventions means that it can be difficult to measure their effectiveness. This is because it is difficult to isolate the effects of a particular intervention owing to the timescales and the range of factors involved; and there is a need for large studies because different people respond so differently.

However, we do have smaller and less formal studies, and the evidence from these clearly suggests that there is enormous potential for preventative interventions to have a substantial impact on people's quality of life and that they may, over time, reduce people's future need for additional care and support.

Moreover, the Department of Health is rising to the challenge and funding high-quality research on both re-ablement and telecare. This will greatly enrich the evidence base over the next few years.

A summary of what currently we know and do not know about a number of interventions is set out in the table at the end of this section.

Effectiveness and cost-effectiveness
When considering prevention, it is important to distinguish between interventions that are effective – i.e. interventions that achieve the outcomes they are aiming at – and interventions that are cost-effective – i.e. interventions that achieve the outcomes they are aiming at with an efficient use of funds.

A cost-effective intervention can have several results within a system: it can be cost-saving (i.e. delivering the same outcomes more cheaply – although this will only work if services that are no longer needed are stopped), cost-neutral (improving the quality of outcomes for the same cost) or cost-increasing (it may be more expensive to carry out a particular intervention, but if it creates major improvements in outcomes it may still be cost-effective).

Although it is very limited, we do have evidence that there are interventions which are effective:

- **Preventative interventions that promote wellbeing:** The available evidence suggests that many preventative interventions seem to promote wellbeing, as measured by the views of people who use or provide the service. For example, the interim evaluation of the POPP programme noted that users reported that they saw their quality of life as improved, and that only 15 out of 470 projects had stated an intention not to continue the services after the initial Department of Health pump-funding finished, indicating that the projects were viewed positively by staff. POPP involved many different projects, with a very wide range of interventions. These included support to access handyman services in Dorset, investment in village halls and support for associated community activities in Herefordshire, creation of volunteering opportunities for older people in Manchester, Tameside and Camden, and crime prevention awareness in Wigan.
- **Interventions that lead to reduced use of more intensive services:** Evidence is also emerging that many interventions may lead to reduced use of more intensive services. For example, re-ablement services may work to reduce the number of people who need intensive care and support after the re-ablement period. In addition, a recent report by the CSCI stated that "a lack of preventative services means there is a short-term dip in the number of people eligible for social care, soon followed by a longer-term rise".[59]

Summary of evidence on selected interventions

	Strength of evidence on effectiveness:

[59] Commission for Social Care Inspection (2008) *Cutting the cake fairly.*

	In promoting wellbeing	In reducing need	Cost-effectiveness
Re-ablement and focused intermediate care has the potential to both lower admissions to nursing/residential care and to reduce demand for domiciliary care. Over 50 per cent of older people who complete a home-based enablement programme do not need social care support following the intervention.	Green/Amber	Green/Amber	Green/Amber
	Available evidence favourable; staff and client views anecdotally positive; but studies are small and short term or else lack controls; they do not look specifically at cost-effectiveness.[60] Many local authorities have, however, saved significantly after investing in re-ablement-based intermediate care.		
Use of technology can lead to a lower use of residential care and, in some cases, less domiciliary care, as well as reducing emergency hospital admissions.	Green	Green (health)/ Amber (social care)	Amber
	Studies suggest potential for telecare services to prevent or delay individuals moving from a low-need to a high-need category; but studies are small and do not look at cost-effectiveness.[61] A 2008 Social Care Institute for Excellence research briefing[62] noted that most of the research to date is based on case studies, and concluded that perceptions vary as to whether or not assistive technology has sufficient benefits. Department of Health-funded work to improve the evidence is ongoing.		
The use of predictive tools, which identify people most at risk of problems, for example people at risk of falls. While current predictive tools identify people at risk of being admitted to hospital, the Department of Health is commissioning software to identify those older people at most risk of needing higher levels of social care.	Green	n/a	n/a
	Current tools aim to target health and social care resources to improve health outcomes (for example, by reducing falls), and the need for health care. Tools to achieve this for social care are currently being developed. Once they are extant, appropriate interventions can be targeted and developed.		
Better health care for older	Green/Amber	Green/Amber/	Amber/Red

[60] For example, De Montfort University/Leicestershire County Council (2000) *Leicestershire County Council External Evaluation of the Home Care Re-ablement Pilot Project* (controlled study, over six weeks, with around 40 people in each group.); Care Services Efficiency Delivery Programme (2007) *Homecare Re-ablement Workstream – Retrospective Longitudinal Study*, www.csed.csip.org.uk(non-controlled retrospective study looking at the experience of four areas over the previous two years).

[61] Poole T (2006) *Telecare and older people*. King's Fund; Prime Minister's Strategy Unit discussion paper on health and social care integration.

[62] Beech R and Roberts D (2008) *Assistive technology and older people*. SCIE Research Briefing.

Intervention	Strength of evidence on effectiveness: In promoting wellbeing	In reducing need	Cost-effectiveness
people may reduce admissions to residential care. Six helpful health interventions have been identified: better dental treatment; stroke recovery programmes; managing and treating incontinence and urinary infections; monitoring liquid intake (reducing dehydration); and podiatry services.		Red	
	There is clear evidence that these conditions are detrimental to wellbeing, and that health interventions can help some people. However, the evidence on how far they impact on residential care admissions is mixed and, in some cases, absent. Local authorities are being encouraged to explore how far these conditions may exacerbate local need; the links to effectiveness and cost-effectiveness have not fully been made.		
Joint health and care support for people with complex needs may reduce admissions to hospitals and residential care. Evaluation of the Bradford Health in Mind POPP programme, which includes intensive support teams that provide community-based support to older people with mental health problems at risk of institutional care, found that: 20 admissions to care homes were prevented; admission to hospital was prevented or delayed for 10 people; and 11 people were discharged from hospital early.	Green/Amber	Red/Amber	Red/Amber
	The early indications from the POPP programme as a whole and the evaluation of this particular project are both very positive. However the evidence on the effectiveness of this specific type of intervention based on this example is weak, as: data are very early; very small numbers are involved; and the conclusions around the preventative impact of the services are based on staff interpretation. Other examples of joint working have been successfully implemented, such as Croydon Primary Care Trust's 'virtual ward' approach, but this is yet to be evaluated.		
Quality of life and wellbeing has become an important aim of some local authorities' and primary care trusts' investment in their communities. For example, Herefordshire has invested in their village halls and the support of local community activities; and Tameside has over 100 older volunteers giving face-to-face information and signposting advice to other older people. Such programmes can make a big difference to people's lives and help build	Green	Amber	Red/Amber
	User satisfaction with these services is generally high – but they are not necessarily aimed at reducing need, and cost-effectiveness has not been measured. A study from Canada[63] found that older people receiving preventative home care were at a 50 per cent higher risk of both death and loss of independence than those not receiving the service.		

Intervention	Strength of evidence on effectiveness: In promoting wellbeing	In reducing need	Cost-effectiveness
social capital, by bringing people together alongside specific services, for example peer support and befriending schemes, housing repair services, good-quality information and advice, and gardening schemes.			

Please note that **falls services** are excluded from this table, as they are already the subject of a National Institute for Health and Clinical Excellence guideline. Many falls services have been shown to be effective in studies from the UK, the USA, Australia and New Zealand. The most effective interventions are those that assess a number of risk factors and tie specific actions to those risks, and exercise-based interventions.

Case study: the evidence on re-ablement

Even where studies suggest that interventions are effective, this does not mean that they are cost-effective or should be a focus for government spending. For example, a home care robot could help people but could also prove more expensive than helping people through traditional home care provided by humans and be less acceptable for people.

To understand whether an intervention is cost-effective, we need to know:

a) whether an intervention works at all
b) when an intervention works
  - For whom, and at what stage in their life, does it work?
  - Where and under what conditions does it work?
c) whether what the intervention achieves justifies its costs
  - How much does it cost?
  - How much does it save?
  - How much does it improve people's lives?

Currently, evidence is beginning to emerge about some of these – for example, studies have found that telecare improves outcomes for some people, in some circumstances, and we have good information about the costs of many wellbeing schemes from the POPPs. However, we do not have large-scale conclusive and comprehensive evidence on cost-effectiveness for any specific preventative interventions.

The intervention for which we have the best evidence is re-ablement. Re-ablement reduces high levels of need by supporting people to learn or relearn skills necessary for daily living, usually after a hospital stay. It is not primary prevention as it does not avoid unplanned or emergency admissions to hospital or residential care in the first instance. Instead, it aims to reduce the level of long-term ongoing support needed by an individual, reduce their likelihood of readmission to

[63] Saskatchewan Health (2000) *The Impact of Preventative Home Care and Seniors Housing on Health Outcomes.*

hospital and prolong their independence. It differs from rehabilitation in that its primary goal is not to 'cure' people from the conditions that give rise to a need for care and support. Rather, it aims to reduce that need to its lowest possible level.

Even for re-ablement, however, a key study[64] has no control group, and states: "Clearly, without robust/detailed baseline data, and a control group for comparison, it is impossible to know whether the patterns of usage seen in the data from the four case study sites are directly and predominantly the result of re-ablement." However, the study also describes "the picture provided by the data of change in homecare usage over the two years after re-ablement" as "very positive". It seems probable that re-ablement programmes are likely to both save costs and help people get on with their lives.

A study of a re-ablement programme in Leicestershire found that people who used this programme were substantially less likely than other people in an otherwise comparable situation to need ongoing care at home. Around 60 per cent of those who had been in re-ablement had their care package discontinued at first review, compared with only 5 per cent in the control group. However, the study was small scale; 42 people were studied after the re-ablement programme, compared with 38 people who hadn't been through the programme – so this means that the results hinge on the experience of 26 individuals who didn't need care. In addition, there were difficulties with the selection of the control group, and the study looked at results after only six weeks rather than in the longer term. Further to this, as of March 2009, over 90 local authorities have some form of re-ablement service already at least partially in place, and 29 are at various stages of establishing a re-ablement service[65]. Clearly, local authorities believe that there is scope for savings here – and, in a recent survey, 75 per cent of local authorities reported that they could see the benefits from their work on prevention, such as enablement. Local authorities typically assume that those people who enter re-ablement programmes would otherwise have received a homecare package on an ongoing basis.

A longitudinal study looked at the experience of people who had been through homecare re-ablement in four areas, two years after the programme had taken place. It found that between 36 per cent and 87 per cent of people didn't require a homecare package after the re-ablement. (Between 77 per cent and 98 per cent of re-ablement users had not had any home care before starting the re-ablement.) It is difficult to draw very strong conclusions from this, as there is no comparable data about similar people who hadn't been through a re-ablement programme, and there may have been other changes going on at the same time, for example tightening of local policies about eligibility for care.

Clearly, the evidence is far from perfect. However, the assumption would, historically, have been that almost all of the people who were eligible for the Leicestershire re-ablement programmes would, in the absence of the programme, have received ongoing homecare support, probably for the rest of their lives.

While the up-front costs of re-ablement are, for any given individual, likely to be greater than those of a homecare package, the balance of evidence available from local authorities, taken along with the two-year longitudinal study, suggests that this one-off, time-limited intervention is, overall, cost-saving, as it reduces people's need for ongoing care at home. This conclusion will be validated by the further work and research that is ongoing. The Department of Health is working to improve the evidence base, with a controlled two-year study on re-ablement due to report in 2010.The policy conclusions will need to remain provisional and subject to further work.

[64] Care Services Efficiency Delivery Programme (2007) *Homecare Re-ablement Workstream – Retrospective Longitudinal Study.* www.csed.csip.org.uk
[65] Homecare Re-ablement CSSR Scheme Directory, Update March 2009.

Annex C: Technical assumptions around modelling of future demographic trends and cost pressures on the care and support system

Population projections and life expectancy

The modelling uses the official Government Actuary's Department (GAD)/Office for National Statistics (ONS) 2006-based principal population projections, which incorporate assumptions about future trends in mortality/life expectancy, fertility and migration.

Marital status and household composition

The modelling uses data from the British Household Panel Survey (BHPS), weighted to the England national level. Characteristics data, such as marital status and household composition, at the baseline year (2006/07) are in the proportions as found in the BHPS. A dynamic micro-simulation model is used to produce the analyses. This approach involves modifying baseline characteristics of individuals in the survey on a year-on-year basis at an individual level. Changes to marital status and household composition after the baseline are made on the basis of analysis of changes between the waves (years) of the longitudinal BHPS. As the population of the BHPS are aged through every year into the future, new 65-year-old people are added to the sample at a rate which offsets the number of people in the population who die in that year in order to maintain the total population at levels projected by GAD for that year. New 65-year-olds enter the sample with the same rate of marital status and household composition as the 2006/07 baseline rate for 65-year-olds. In other words, these characteristics remain constant through time for 65-year-olds. As individual people age after 65, their characteristics change according to the estimates from BHPS. For example, as individual people age they are more likely to become single and live alone.

Disability rates

For older people, the modelling uses – as a base case – constant age/gender-specific prevalence rates of disability in terms of instrumental activities of daily living (IADLs) and activities of daily living (ADLs). This suggests falling age/gender-specific incidence rates, in view of rising life expectancy. As people age in the BHPS sample, disability state is set to change to maintain the same distribution in each one-year-age-gender group through time (even though the population size in these one-year-age-gender groups can vary year on year).

For younger adults with physical and sensory disabilities, a similar assumption is made of constant prevalence rates of disability. For younger adults with learning disabilities, the base case is based on the projected proportionate increase in numbers of adults with learning disabilities requiring social services in the middle scenario of Table 4 of *Estimating Future Need for Adult Social Care Services for People with Learning Disabilities in England.*[66]

Informal family care

The incorporation of the official marital status projections means that the modelling implicitly takes account of projected changes in the potential supply of informal care by spouses/partners. For care by adult children and other relatives, the base case assumes that supply will rise in line with projected demand.

Unit costs of care services

The costs of the labour and capital components of services are assumed in the base case to rise in line with HM Treasury long-term assumptions for average earnings, i.e. by 2 per cent per

[66] Emerson E and Hatton C (2008) *Estimating Future Need for Adult Social Care Services for People with Learning Disabilities in England*. CeDR Research Report 2008:6. Centre for Disability Research, Lancaster University.

year in real terms (as per HM Treasury long-term public finance analyses). Overall, the costs of services (residential and community-based) are assumed to rise by 2 per cent in real terms. The base case assumption does not take account of any rise in the quality of care (which could increase costs), and does not assume any productivity savings (which could lower costs).

Attendance Allowance

Uptake of Attendance Allowance is also derived. The BHPS records use of these benefits and this data is used to predict (with regression analysis) people's likelihood of claiming these benefits at baseline. The predicting factors are: need (activities of daily living count and limiting long-standing illness), age, gender, income and (non-housing) assets. This approach is used to ensure that Attendance Allowance uptake and spend corresponds to Department for Work and Pensions published levels for the benefit at the baseline year.

For estimates of future values of Attendance Allowance (i.e. after the baseline), we use a constant age-gender-need prevalence approach. In other words, the proportion of people claiming AA within each population grouping by age, gender and need remains constant through time. Each year, recipients will be those people that were in receipt last year plus new recipients in each population group required to maintain a constant prevalence. It is assumed that people in receipt of AA in the past remain in receipt for life.

Housing and non-housing assets

Home ownership rates and the value of housing assets are given for the baseline year according to the values in BHPS and calibrated with data from the English Longitudinal Survey of Ageing (ELSA). Non-housing assets are determined in the same way. For new 65-year-olds entering the sample in future years, both housing and non-housing assets are assumed to be 2 per cent higher in real terms than those of 65-year-olds in the previous year. For people ageing in the sample after the base year, the following processes affect the size of asset values. First, spend-down of assets where spending in that year on care and cost of living exceeds income. Second, saving from any remaining income at a rate given by analysis of the BHPS (and at a 2 per cent real terms rate of return) add to non-housing assets. Third, capital gains accrue to remaining housing assets (at a rate of 2 per cent in real terms). Fourth, people are assumed to make non-care-related draw-downs of assets at a rate of approximately 5 per cent per year (although it is modelled in a non-continuous way). These processes were specified to produce a profile of asset holding that matches people in the BHPS. The rate of change in these processes is assumed to be constant through time.

Real pensioner incomes

A distinction needs to be made between: (a) changes in the incomes of individual pensioners; and (b) changes in the incomes of all pensioners on a cross-sectional basis. The key point is that (b) takes account of the trend for each successive cohort of people reaching pension age to have higher real incomes than the previous cohort.

The PSSRU micro-simulation modelling distinguishes benefits income, pension incomes and other incomes. For new 65-year-olds in the sample, all income is assumed to be 2 per cent higher in real terms than that of 65-year-olds in the previous year (analogous with the treatment of assets). For people ageing in the sample after 65, income-related benefits income (i.e. Pension Credit) is assumed to increase by 2 per cent (in line with increases in earnings). Disability-related benefits are assumed to remain constant in real terms. All other benefits increase at 2 per cent. Pension income is also assumed to increase at 2 per cent per year in real terms (from 2007 as a simplifying assumption, rather than from 2012). Earnings income is assumed to fall (by an average of 5 per cent per year) to reflect older people dropping out of the workforce. All other sources of income are assumed to remain constant.