Volume II

Fairer Care Funding

Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support

July 2011
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This report accompanies the Commission’s main publication and sets out in greater detail the analysis and evidence that underpins our recommendations.

Alongside this report, the Commission has also published a number of supporting documents. For convenience, these have been brought together in a separate volume (volume III) of the report, which includes:

1. **Call for Evidence**
   - Call for Evidence
   - Summary of responses to the Call for Evidence

2. **Input to 2010 Spending Review**
   - Letter providing input to the 2010 Spending Review
   - Government response to the Commission’s letter

3. **Public opinion research**
   - Ipsos MORI literature review on public opinion research on social care funding
   - TNS-BMRB deliberative research report

All these documents are available on the Commission’s website at: www.dilnotcommission.dh.gov.uk.
Summary of key findings and recommendations

Key findings

• The current adult social care funding system in England is not fit for purpose and needs urgent and lasting reform.

• The current system is confusing, unfair and unsustainable. People are unable to plan ahead to meet their future care needs. Assessment processes are complex and opaque. Eligibility varies depending on where you live and there is no portability if you move between local authorities. Provision of information and advice is poor, and services often fail to join up. All this means that people frequently do not have good experiences.

• A major problem is that people are unable to protect themselves against very high care costs. The current availability and choice of financial products to support people in meeting care costs is very limited. There is great uncertainty and people are worried about the future.

• Most people are realistic about the need for individuals to make some contribution to the costs of care in later life. But people want a fairer way of sharing costs and responsibility between the state and individuals and they want to be relieved of fear and worry. There is consensus on the need for reform.

Our main recommendations

1. To protect people from extreme care costs we recommend capping the lifetime contribution to adult social care costs that any individual needs to make at between £25,000 and £50,000. We think £35,000 is an appropriate and fair figure and have used this example throughout our report. Where an individual’s care costs exceed the cap, they would be eligible for full support from the state. This change should bring greater peace of mind and reduce anxiety, for both individuals and carers.

2. Not everyone will be able to afford to make their personal contribution, and those currently just outside the eligibility for means-tested help are not adequately protected. To address this, means-tested support should continue for those of lower means, and the asset threshold for those in residential care beyond which no means-tested help is given should increase from £23,250 to £100,000.
3. People born with a care and support need or who develop one in early life cannot be expected to have planned in the same way as older people. **Those who enter adulthood already having a care and support need should immediately be eligible for free state support to meet their care needs, rather than being subjected to a means test.**

4. Universal disability benefits for people of all ages should continue as now. **We recommend that the Government considers how better to align benefits with the reformed social care funding system and that Attendance Allowance should be re-branded to clarify its purpose.**

5. **People should contribute a standard amount to cover their general living costs, such as food and accommodation, in residential care.** We believe that a figure in the range of £7,000 to £10,000 a year is appropriate.

6. **We recommend that eligibility criteria for service entitlement should be set on a standardised national basis to improve consistency and fairness across England and that there should be portability of assessments.** In the short term, we think it is reasonable for a minimum eligibility threshold to be set nationally at ‘substantial’ under the current system.¹ **The Government should also urgently develop a more objective eligibility and assessment framework.**

7. **To encourage people to plan ahead for their later life, we recommend that the Government should invest in an awareness campaign.** This should inform people of the new system and the importance of planning ahead. This campaign could be linked into the wider work to encourage pension savings.

8. **The Government should develop a major new information and advice strategy to help when care needs arise.** It is critical that the public has access to better, easy-to-understand and reliable information and advice about services and funding sources. This strategy should be produced in partnership with charities, local government and the financial services sector. As proposed by the Law Commission, a statutory duty should be placed on local authorities to provide information, advice and assistance services in their areas. These should be available to all people, irrespective of how their care is funded or provided.

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¹ The Fair Access to Care Services (FACS) framework was introduced in 2003. It was replaced by *Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care* published on 25 February 2010.
9. **Carers should be supported by improved assessments which take place alongside the assessment of the person being cared for and which aim to ensure that the impact on the carer is manageable and sustainable.** We support the proposals set out by the Law Commission to give carers new legal rights to services and improve carers’ assessments. In implementing our recommendations on information and advice, the Government should ensure that carers have better information and advice about support and available services.

10. **In reforming the funding of social care, the Government should review the scope for improving the integration of adult social care with other services in the wider care and support system.** In particular, we believe it is important that there is improved integration of health and social care in order to deliver better outcomes for individuals and value for money from the state.

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**How do our proposals help individuals and families?**

Under our core funding proposals, we are capping an individual’s lifetime care costs and extending the upper threshold for means-tested state support from £23,250 to £100,000. Figure 1 shows how making these two changes significantly reduces the proportion of assets people face losing compared to the current system.

Under the current system someone who has lifetime care costs of £150,000 could lose up to 90% of their accumulated wealth. The combination of the capped cost model (with the cap set at £35,000) and the extended means test would ensure that no one would have to spend more than 30% of their assets on their care costs.
We need to spend more on social care – both now and in the future. This needs to come from both individuals and the state.

We think that the reforms we have set out will help people to manage their contribution better, for example by helping people plan and prepare and by encouraging the development of new financial products.

Individuals and families will need to consider how best to meet their contribution. Many of the people we have spoken to, and who submitted evidence to the Commission, have said that it is not unreasonable that people should plan and prepare to meet some care costs as they grow older. To support this, under our proposals, disability benefits will continue as now, we recommend that there should be a more widely available deferred payment scheme, and we anticipate new financial products would emerge.

Clearly, the state will need to continue to support the vast majority of younger people with care and support needs.

The Government should both implement our reforms and ensure that there is sufficient, and sustainable, funding for local authorities. Local authorities will need to be able to manage existing pressures as well as the new requirements resulting from our reforms.

2 This chart assumes residential care costs of £28,600 p.a. and individual income just sufficient to cover a contribution to general living costs of £10,000 p.a.
The Government must devote greater resources to the adult social care system. As well as funding for new reforms, additional public funding for the means-tested system is urgently required. The Commission recognises the Government’s commitment to social care in the latest Spending Review settlement. However, the impact of the wider local government settlement appears to have meant that the additional resources have not found their way to social care budgets in some areas. We suggest that the resources made available locally for adult social care each year should be transparent. Any periodic review of local government financing should have regard to the importance of the sustainability of funding for adult social care.

→ We estimate that our recommended changes to the funding system would cost from around £1.3 billion for a cap of £50,000 to £2.2 billion for a cap of £25,000.³

³ Public expenditure cost (in 2010/11 prices) were our recommended changes fully implemented in 2010/11.
Part 1: Reasons for reforming the adult social care funding system
1.1 Introduction

What is care and support?
Social care supports people of all ages who find themselves in vulnerable circumstances – as they get older, and if they have a disability or mental health condition. It assists people with certain physical, cognitive or age-related conditions in carrying out personal care or domestic routines. It helps people sustain involvement in paid or unpaid work, education, learning, leisure and other social support systems. It supports people in building social relationships and participating fully in society.

Social care is part of a wider care and support system which includes social care, the NHS, the social security system, housing support and public health services. It also includes the services provided by third-sector organisations, and the invaluable contribution made by carers and volunteers. The state pension and private financial products also provide income which is used for care and support needs. The Commission believes that it is important to look at all the different aspects of care and support together. Firstly, because we know that people want to receive a coherent package of support – one shaped around them, not funding streams – and secondly, because aligned and integrated services offer better value for money.

Scope of the report
The proposals in this report cover all adults in England: both older people and younger adults. Our proposals do not cover children, although there may be areas (such as a national eligibility framework and improved information and advice) where the interactions between the two systems will need to be considered by central and local government. The recommendations for reform of the funding system for adult social care are for England only, but the Commission has consulted with the devolved administrations throughout its work. We expect the Government will continue to engage with the devolved administrations as it takes reform forward.
The Commission on Funding of Care and Support

In July 2010, the Government asked Andrew Dilnot to chair the Commission on Funding of Care and Support. Lord Norman Warner and Dame Jo Williams were asked to serve as fellow commissioners. The Commission was asked to submit its final report to the Government by the end of July 2011.

The Coalition Government announced its intention to set up the Commission on Funding of Care and Support in the Coalition Agreement, *The Coalition: our programme for government.*

The Government believes that people needing care deserve to be treated with dignity and respect. We understand the urgency of reforming the system of social care to provide much more control to individuals and their carers, and to ease the cost burden that they and their families face.

We will establish a commission on long-term care, to report within a year. The commission will consider a range of ideas, including both a voluntary insurance scheme to protect the assets of those who go into residential care, and a partnership scheme as proposed by Derek Wanless.

*Momentum for reforming the funding of the adult social care system has been developing over time. The formation of the Commission builds on a number of high-profile reviews, including the Royal Commission on Long Term Care; the Wanless Social Care Review, *Securing Good Care for Older People,* and the previous Government’s White Paper, *Building the National Care Service.* These reviews have advocated a range of different approaches – including free personal care, social insurance and partnership approaches.*

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2 *With Respect to Old Age: Long Term Care – Rights and Responsibilities*, Report by the Royal Commission on Long Term Care, 1999.
Terms of Reference

The Commission’s remit was set by the Government in our Terms of Reference:

Terms of Reference for the Commission on Funding of Care and Support

The Commission is asked to make recommendations on how to achieve an affordable and sustainable funding system or systems for care and support, for all adults in England, both in the home and other settings. The Commission should build on the extensive existing body of work in this area and provide advice on how to implement its chosen options.

The approach recommended must be affordable and sustainable in both the short and long term. It must be consistent with the Government’s deficit reduction plan as set out in the June 2010 Budget and the Spending Review, and be sustainable for the public finances in the long term in the context of an ageing society. The Commission should present its initial views to the Secretary of State for Health and the Chief Secretary to the Treasury in order for these to be taken into account in the upcoming Spending Review.

The work of the Commission should support reform of the whole system, ensuring that the right care is available at the right time, and in the right place, for individuals and their families. It must also be compatible with the Government’s vision for care and support – supporting personalisation, prevention and partnership and offering protection for people. It should take into account how appropriate housing and related services can better support people with disabilities and in later life.

Furthermore, the Commission should consider the relationship its work has with the conclusions of the Government’s wider work on welfare reform later this year. Based on these conclusions, the Commission will then be able to examine the interaction between the social care system and the GB-wide benefit system, and consider the impact of its proposals on savings and work incentives.
The Commission is asked to examine and provide deliverable recommendations on:

- how best to meet the costs of care and support as a partnership between individuals and the state;

- how people could choose to protect their assets, especially their homes, against the cost of care;

- how, both now and in the future, public funding for the care and support system can be best used to meet care and support needs; and

- how its preferred option can be delivered, including an indication of the timescale for implementation, and its impact on local government (and the local government finance system), the NHS, and – if appropriate – financial regulation.

The Commission should judge funding models against set criteria, which it should agree, and present to the Government for approval, within the first two months. The assessment should include the following criteria:

- **choice**: offering an affordable choice to individuals, carers and families across a range of care settings, and helping people to plan and prepare for the future;

- **fairness**: for individuals, families, carers and wider society;

- **value for money**: securing the highest quality care outcomes with the available resources; and

- **sustainability**: ensuring that the costs to the state are sustainable in the context of an ageing population.
In assessing options, the Commission will also be expected to take account of:

- earlier work carried out on the issue, including the Green Paper, *Shaping the Future of Care Together*, the King’s Fund report, *Securing Good Care for More People*, the proposals for a Home Protection Scheme published in October 2009, and other academic research, international experience and public consultations;

- evidence from stakeholders – the Chair should consider convening an external reference group which includes, as a minimum, those representing older people, working-age adults with disabilities, carers, those commissioning and delivering care (including the views of local authorities) and the financial services sector;

- the views of those using services and the wider public on the trade-offs associated with achieving a sustainable funding system; and

- the interests of the devolved administrations, where appropriate.

The Commission should present its recommendations for consideration by the Chancellor and Secretary of State for Health by the end of July 2011 at the latest. The Chancellor and Secretary of State for Health will then consult with the Departments for Work and Pensions and for Communities and Local Government, and relevant colleagues, before presenting their recommendations to the Prime Minister and Deputy Prime Minister.

Criteria

As part of our Terms of Reference, we were asked to agree the criteria by which we would judge possible funding options with government. Building on the criteria set out in the Terms of Reference, we agreed a set of five criteria and two principles, which we thought ought to underpin the social care system.
The Commission’s criteria

- **Sustainable and resilient**: ensuring that the costs to the state are sustainable in the long term, and that the care and support system is able to respond to demographic, economic, political and societal change.

- **Fairness**: for individuals, families, carers and wider society.

- **Choice**: offering an affordable choice to individuals, carers and families across a range of care settings, and helping people to prepare and plan for their future.

- **Value for money**: securing the highest quality care outcomes with the available resources.

- **Ease of use and understanding**: making the system as clear and as simple as possible for people, supporting people to take responsibility for their future well-being.

Underpinning principles

- **Promotion of the well-being of individuals and families** – enabling people to maintain their dignity, protecting those in the most vulnerable circumstances, and helping everyone to participate in the wider community.

- **Recognition of the valuable contributions of everyone involved in care and support**, including individuals; carers and families; volunteers and professional carers; private, public and charitable sector organisations; taxpayers; and wider society. As outlined in the Terms of Reference, our recommendations will cover all adults in England – working-age and older people.

Our work

As a substantial amount of work had already been done in this area over recent years, we first considered the body of evidence already gathered. Over the course of our work, we conducted further analysis and sought the views of a range of different people and organisations. We have spoken to many charitable organisations, think tanks, academics, representatives of the financial services sector and those currently providing and experiencing services, and we have examined the social care funding models of other countries. We have also spoken to central and local government throughout out work, and to the devolved administrations.
The Commission set up an external reference group of key stakeholders, in order to share our thinking and test emerging ideas. We are grateful to all those who gave their time to be on our reference group. A full list of all those on the external reference group is provided in Annex B.

The Commission also established a panel of academics, including experts on social care, ageing and public policy, all of whom have helped us to gather relevant research and conduct our analysis. A full list of members of our academic panel is also given in Annex B.

Call for Evidence

In December 2010, we launched a Call for Evidence. This document summarised the challenges and opportunities we see facing the care and support system. The report evaluated the current system, and set out our direction of reform.

Direction of reform

In the Call for Evidence, we set out four priorities that needed to be addressed in designing a sustainable settlement. These were as follows:

- People should have the opportunity to be protected against the future cost of care and support.
- People need to understand how the care and support system works and be encouraged to plan accordingly.
- People need to be clear about the role of the wider system of public support (including the NHS and social security).
- Increased resources – public, private and voluntary – will need to be dedicated to care and support in the future.

The Commission received over 250 responses to the Call for Evidence, which were generally supportive of the direction of travel:

- There was considerable support for a funding model where the state and the individual each make a contribution towards the cost of care.

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5 Our Call for Evidence and other documents that the Commission has published during its work are published in a separate report alongside this document. They are also available on our website at www.dilnotcommission.dh.gov.uk.
• Many commented on the need for carers to be supported in playing their valuable role.

• There was a widespread call for the continuation of some sort of means-tested system for those with high needs unable to afford to meet the costs of care.

• Responses strongly argued for extra resources for the adult social care system to cope with increasing demands in the future and to reduce unmet need in the current system.

• More effective integration of health and social care services was felt to be essential, especially around end-of-life care and for those with complex needs. Other areas of support, such as housing and benefits, also needed to work effectively with social care services.

• There was a strong call for people to be made aware of the need to plan for the future and for provision of improved information and advice on both the funding and the delivery of care, to support them in doing so.

• It was also felt that the funding system needed to ensure appropriate support for those of working age in need of care and support.

In addition, responses also highlighted the need for a:

• more streamlined system – with greater joined-up working between different professionals, better assessment processes, more timely responses and portability of assessments;

• national eligibility and assessment framework for care and support, so that people can clearly understand what they are entitled to, and when they will receive support from the state. However, it was argued that there should still be flexibility in the delivery of services; and

• greater focus on early intervention, to prevent needs escalating, deliver improved outcomes and help to manage costs.

Research with the public

Public attitudes towards paying for care and support

In addition to our Call for Evidence, we felt that it was important to understand the views of the general public better. To do this, we commissioned Ipsos MORI to undertake a literature review of public opinion research on the issue of social care funding undertaken prior to the Commission’s establishment.\(^6\)

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\(^6\) Public opinion research on social care funding: A literature review on behalf of the Commission on the Funding of Care and Support, Ipsos MORI Social Research Institute, 2011.
The research suggests that there is very low awareness of how care and support are funded, although people do believe that caring for older people is a priority. People do not feel well-informed, meaning that very few people are planning to save for future care needs. Furthermore, findings indicate that people are often unable to distinguish between social care and health services. This can lead to confusion over which services are free and which are not.

When asked about the current system, many thought that it was unfair – although people’s perceptions of what is, and what is not, ‘fair’ are complex. Studies show that people think that some responsibility for funding social care should lie with the state – often through the NHS. However, international comparisons suggest that British people are more willing to share responsibility and make a personal contribution compared with people in other countries.

**Deliberative research**

The Commission undertook a programme of deliberative research to better understand public views on different types of funding options and the trade-offs people are willing to make. The research also explored whether there were any specific equality issues that needed to be taken into account.

During the research, people expressed strong agreement with the need to reform our current system. The principle of individuals taking some financial responsibility for their care and support funding was accepted, albeit not universally. Individual responses varied in response to a number of factors, including the level of income and assets, perceptions of fairness and attitudes towards risk.

Overall, there was a strong desire among the public for a clear and resilient resolution, as well as for the Government to be clear about the need for reform, to be honest and upfront about the level of individual contributions required, and – in future – not to change these requirements.

The full report of our deliberative research has been published in our pack of supporting documents.

**Economic modelling and analysis**

The Commission’s analysis of costs and distributional impacts of different funding models draws on results from simulation models. Most of the modelling work was commissioned as part of the core programme of

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7 *Public engagement exploring care and support funding options*, TNS-BMRB on behalf of the Commission on Funding of Care and Support, 2011
the policy research unit in economics of health and social care systems (also referred to as ESHCRU at the University of York, London School of Economics and Political Science (LSE) and the University of Kent), and builds on the microsimulation and aggregate models originally developed by the Personal Social Services Research Unit (PSSRU at the University of Kent and LSE). The work was funded by the Department of Health.

We commissioned an independent review of the PSSRU microsimulation model, which was undertaken by the Institute for Fiscal Studies (IFS); and microsimulation work from the University of East Anglia on the evolution of gross incomes and assets of people requiring care.

A discussion of these models is presented in Annex A of this report.

Outputs of the models, both final and intermediate, were continuously reviewed by the Secretariat, cross-checked against each other and against estimates from heuristics. This has provided the Commission with assurance that the models and the results they produce are reliable. We understand that the Department of Health will also be conducting a peer review of the modelling work undertaken as part of the ESHCRU programme.

We have also drawn on the latest results from the Newcastle 85+ Study, the English Longitudinal Study of Ageing (ELSA), and the Wealth and Assets Survey.

Input into the Spending Review

As part of our work, we were asked by the Government to input our initial views into the 2010 Spending Review process. In our submission, we outlined our aim to design a practical, realistic and deliverable settlement, but noted that this would require making trade-offs and difficult judgements.

We argued that, in the medium and long term, there would be increased demand on the care and support system. Even for the state to maintain the current system, at the current levels of support, significant additional public resources would be required. We said that the Government needed to take account of demographic change and increasing levels of disability, but also people’s rising expectations and increased wealth. We also put forward the case for looking at adult social care in the context of the wider streams of public funding currently supporting older people – the NHS, disability benefits and the state pension. A copy of the letter is provided in the supporting documents pack, accompanying this report.
Related areas of work
In addition to the work of our Commission, there have been a number of other significant reviews and reports conducted in parallel.

The Commission very much welcomes the report of the Law Commission, *Adult Social Care*.8 The report outlines a move towards a clearer and more coherent legal framework for adult social care. While the Law Commission’s report is about reforming the legislation and not the system per se, it starts to address some of the concerns about the system that were raised in the responses to our Call for Evidence and we think that it provides a strong basis for the proposals and suggestions in our report.

The Government published its vision for adult social care in 2010.9 Again, the Commission welcomes the direction of travel outlined in the vision and is supportive of the key principles. In particular, we are supportive of the personalisation agenda and the roll-out of personal budgets; we see the necessity of improving the quality of social care services, and the need for more integrated working between different services.

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1.2 Case for reform

The current adult social care funding system in England is not fit for purpose and needs urgent and lasting reform.

The system, conceived in 1948, is not fit for purpose. People are exposed to very high costs, which they are unable to protect themselves against. The system is confusing, unfair and unsustainable. People are unable to plan ahead to meet their future care needs. Assessment processes are complex and opaque. Eligibility varies depending on where you live and there is no portability of assessments if you move between local authorities. Provision of information and advice is poor. Services often fail to join up. All this means people can experience poor outcomes and face considerable distress.

Funding has also not kept pace with demand. Demographic change and rising expectations will lead to increasing demand for care and support, putting further pressure on the system.

Given these pressures, greater resources will need to be devoted to the adult social care system in the future.

Introduction

In this section, we explore the case for reform of the system. The case has been set out many times before, notably by Sir Derek Wanless in his report on social care funding, but also by previous governments and by think tanks. However, in order to come up with our recommendations, we felt it was important to analyse the issue from first principles. We first set out our analysis of the strengths and weaknesses of the current system in our Call for Evidence; and the responses we received supported our analysis of the weaknesses of the current system. There was a strong call for comprehensive and urgent reform in the responses we received.

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**Our current adult social care funding system**

The social care system in England provides care and support through a means-tested system delivered at the local level by local authorities. Very broadly, under this system, people with assets over £23,250 receive no financial state support and need to fund their own care. The level and type of state support for people with assets below this threshold depends on their needs and income.

There are currently different rules for domiciliary and residential care. In residential care, someone’s housing assets (as long as there is no partner still living in the home) are taken into account in the means test.

The state currently spends £14.5 billion p.a. on adult social care in England. Just over half of this spending is on services for older people.

**Figure 1.1: Public expenditure on adult social care, 2009/10**

![Diagram showing public expenditure on adult social care, 2009/10](image)

*Source: Personal Social Services Expenditure and Unit Costs: England 2009-10 – Final Council Data, The Information Centre; Department of Health*

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2 “Other” includes social care strategy, asylum seekers and other expenditure
Figure 1.2: The current care and support system in England, 2009/10 – facts and figures

<table>
<thead>
<tr>
<th>Numbers (’000)</th>
<th>18–64</th>
<th>65+</th>
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<tbody>
<tr>
<td>Population (2010)</td>
<td>32,600</td>
<td>8,580</td>
</tr>
<tr>
<td>Social care</td>
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<td></td>
</tr>
<tr>
<td>Publicly supported</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Residential care</td>
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<td>- Community care</td>
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<td>610</td>
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<td>- Community care</td>
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</tr>
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<td>Unpaid care</td>
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<tr>
<td>Social security disability benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability Living Allowance (DLA) and Attendance Allowance (AA)</td>
<td>1,600</td>
<td>2,200</td>
</tr>
</tbody>
</table>

| Spend (£) | | |
| Social care | | |
| Public expenditure (net of user charges and other income) | £6,500m | £7,500m |
| Private spend on social care | NA | £8,300m |
| Social security disability benefits | | |
| DLA (care component) and AA | £5,100m | £6,600m |

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4 NA stands for not available.
Why is reform necessary?
The Commission acknowledges that the current system has some strengths. It focuses limited resources on those with the lowest means, and then within that group those with high needs, and allows local authorities some flexibility over costs. In recent times, improvements have been made in the delivery of care through increased personalisation – giving individuals and families greater choice and control. There have also been positive developments in areas such as prevention, and innovations in service delivery such as re-ablement and crisis response. The current system is also highly responsive to local circumstances; and we know that there are many community-based organisations and private providers that are delivering quality services.

There are, however, many shortcomings. Below we outline the main concerns that we have identified, which lead us to support the call for major reform of the funding system.

People are exposed to potentially very high care costs
Under the current funding system, there is no way individuals can protect themselves from potentially very high care costs by pooling their risks. People can lose the majority of their income and assets paying for care. Those entering residential care are often forced to sell their homes. This is widely perceived by the public to be unfair.

At the age of 65, the future costs of care are unpredictable. Around a quarter of people aged 65 will face no significant care costs over the remainder of their lives, while around one in ten people face future lifetime care costs of more than £100,000.\(^5\) For those born with a disability, or who develop a care and support need during their working life, lifetime costs can be considerably higher. The current system leaves everyone exposed to these potentially very high costs and the fear and uncertainty that this brings.

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\(^5\) Data on the costs of social care are poor, especially for those receiving domiciliary care. The costs presented here – and throughout this paper – are the results of modelling work carried out for the Commission by the Personal Social Services Research Unit (PSSRU).
It is not possible for a person to predict with any certainty where they will be in this distribution, so – in the absence of insurance options – a 65-year-old has two choices: they either accept that they run the risk of spending all of their assets on care and then falling onto state support; or they attempt to plan for the possibility of very high care costs through saving. Neither of these options is efficient or desirable.

For any other activity which has this type of risk, people are able to take out insurance, or are covered by tax-funded social insurance. However, a combination of demand- and supply-side problems has left the insurance industry unable to provide attractive products, and there are currently no major financial services providers offering pre-funded insurance against care costs. There is a section on the role of the financial services, which sets out further detail, later in the report (see Section 3.3).

The result of this is that people may have to deplete their assets significantly. Figure 1.4 illustrates the maximum possible asset depletion of people should they face £150,000 of care costs.
The current system delivers inconsistent services

There is unacceptable variation in eligibility for services across the country

Local authorities are well placed to understand and respond to the priorities and needs of their population – not just for direct social care services, but also for wider housing, health, education, employment and leisure services.

There are, however, tensions between this local responsiveness and the public’s notion of fairness. One of the key concerns raised in the responses to our Call for Evidence was that there is a ‘postcode lottery’ of care, where entitlement to services differs across the country. Having eligibility determined at the local level leads to high variability among the 152 local authorities in England.

As we have gathered our evidence, we have also concluded that the current approach to assessing eligibility for care – Fair Access to Care Services

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6 This chart assumes residential care costs of £28,600 p.a. and individual income just sufficient to cover a contribution to general living costs of £10,000 p.a. Housing wealth percentiles relate to homeowners only.

7 This is further supported by the Summary of the ‘Big Care Debate’ Consultation, Department of Health, 2010.

8 Currently each local authority carries out a financial assessment of what the person can afford to pay. While for residential care there are national regulations on charging, for domiciliary care local authorities can design their own charging policies within the overall national guidance. This leads to variation.
(FACS) – lacks transparency and clarity. It takes into account a wide variety of factors but lacks objectivity. In particular, people are not able to work out whether or not they are eligible for local authority support.

Assessments are not portable
Assessments are currently not portable. Many people have told us that they are very frustrated by the fact that if they move to a new local authority, they lose their care until they are reassessed by the new local authority. People should not feel trapped and unable to move should they want to. This lack of portability is a real barrier to people having choice and control over their care.

The system is complex and difficult to understand
There is low awareness of how the system works and provision of information and advice is poor
Currently, many people are unaware of how the adult social care system operates and what they can expect from it. Many believe that they will receive free care in later life – because they mistakenly believe that they have been paying for this through National Insurance or that it is part of the NHS. This leads to a lack of planning and saving. People are often shocked when they discover the scale of their financial liabilities at the point when they, or a family member, need care.

Once people enter the system, it is complicated to navigate. People often complain of a lack of adequate information, advice and signposting. There are examples of some good practice, but on the whole our evidence strongly suggests that people are bewildered and confused by the system and do not know where to go or who to talk to for advice.⁹

The wider care and support system is not properly joined up
There are significant overlaps between the different public funding streams for care and support. People can receive support from the state through the social care system, disability benefits and the NHS. Some will be receiving housing benefit. Older people will receive the state pension and may receive other means-tested social security benefits, and younger people may be claiming other work-related benefits. This can be very confusing.

Currently, these different streams do not always work effectively together and there are multiple assessments. There have been attempts across the country to integrate services – and there are some examples where this has worked well. However, these examples have not been scaled up, and many people are still experiencing disjointed service delivery. Poorly

⁹ See: Public opinion research on social care funding: A literature review on behalf of the Commission on Funding of Care and Support, Ipsos MORI Social Research Institute, 2011.
integrated services mean that people and families often face multiple assessments and poorly co-ordinated services, while the state is not getting the best value from the money it is spending.

In particular, people are often confused over the boundary between social care and the NHS (especially around NHS Continuing Healthcare). For those caught on the boundary between the two, it can seem unfair that two funding systems operate (one free at the point of need, and one means tested) for needs which arguably lie on the same spectrum. Better integrated services could help.

We also know that around 70–80% of people receiving social care at home also receive AA, but 29% of those receiving AA receive neither unpaid nor formal care. Within our current system, there is a plurality of different benefits, administered at different levels and by different agencies, which can be highly confusing for people and expensive to administer. Not everyone will be receiving the support to which they are entitled.

People may not be receiving the care and support they need
Throughout our work, people have pointed to increasing numbers of people not getting the care and support that they need.

Eligibility thresholds have been rising
Local authorities set needs thresholds, based on the FACS criteria, for eligibility for means-tested support. In 2005/06, around 60% of local authorities set thresholds at ‘substantial’ or ‘critical’; this has risen to 82% of local authorities in 2010/11. Between 2009/10 and 2010/11, 10% of local authorities increased their thresholds from ‘moderate’ to ‘substantial’.

Expenditure on adult social care has not kept pace with demand
Figure 1.5 shows real expenditure growth since 1994/95 on older people and younger adults as an index. In the 15 years from 1994/95 to 2009/10, real spending increased by around 70% for older people and by more than 150% for younger adults. Over the same period, real spending in the NHS has risen by almost 110%.

It should be noted that, over this period, there have been significant transfers of responsibility between social security, the NHS and social care, pay and prices in social care have risen more quickly than general inflation, and there have been rising levels of demand as the number of older people and younger adults with a care need has risen.

11 CSCI; Association of Directors of Adult Social Services budget survey 2011.
Figure 1.5: Public expenditure on social care by client group (index, 1994/95=100)


Figure 1.6 shows real expenditure on personal social services since 2005/06 against projected demand. Projected demand takes account of both real unit cost growth (using the personal social services pay and prices index) and demographic change. Over the four years between 2005/06 and 2010/11, demand has outstripped expenditure by around 9%.

Figure 1.6: Expenditure and demand – older people’s social care (2009/10 prices)

The number of people receiving services has fallen

Figure 1.7 shows the number of service users by year as an index. The number of people using residential care and home care services has fallen by around 20% since 2003, but there has been a large growth in community-based services. The number of home care contact hours has risen, suggesting that home care services have been progressively targeted at the most needy people, but even this fell in 2010, as did the number of users of community-based services.

Figure 1.7: Number of service users, by service type (index, 2001=100)\textsuperscript{12}

![Graph showing number of service users by service type]

Source: Community Care Statistics, Social Care Activity, England, 2009-10 (further release), The Information Centre.

Evidence suggests that there is considerable unmet need

It is hard to quantify the absolute level of unmet need. Unmet need is difficult to define and measure, but the trends in expenditure and demand outlined above give us an indication that unmet need is increasing. This view was supported in responses to our Call for Evidence in which a number of organisations expressed concerns about unmet need.

In the 2006 report Securing Good Care for Older People,\textsuperscript{13} the additional cost of providing a ‘benchmark’ level of care was estimated – based on meeting need in a cost-effective way. This required a 25% increase in expenditure on 2002/03 levels of expenditure. Taking account of the increases in expenditure since 2002/03 suggests that the 2009/10 expenditure would need to rise by 17% to provide the benchmark level of care. This would require an additional £1.2 billion.

\textsuperscript{12} This chart shows number of service users at 31 March. Home care contact hours are indexed to 2005, when the data series starts.

\textsuperscript{13} Securing Good Care for Older People: Taking a long-term view. Wanless D, King’s Fund, 2006.
Social care is one of many priorities for local authorities

Social care is a significant proportion of local authority spending. Figure 1.8 shows that, in 2009/10, net current expenditure on social care was just over 30% of the total local authority budget (excluding education and police).

Figure 1.8: Local authority net expenditure by service, 2009/10

<table>
<thead>
<tr>
<th>Service</th>
<th>Net current expenditure (£ billion)</th>
<th>Proportion of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult social care</td>
<td>14.6</td>
<td>30.9%</td>
</tr>
<tr>
<td>Highways and transport services</td>
<td>6.5</td>
<td>13.9%</td>
</tr>
<tr>
<td>Children’s social care</td>
<td>6.4</td>
<td>13.6%</td>
</tr>
<tr>
<td>Environmental and regulatory services</td>
<td>5.3</td>
<td>11.2%</td>
</tr>
<tr>
<td>Cultural and related services</td>
<td>3.5</td>
<td>7.4%</td>
</tr>
<tr>
<td>Central services</td>
<td>3.4</td>
<td>7.2%</td>
</tr>
<tr>
<td>Housing services</td>
<td>2.7</td>
<td>5.8%</td>
</tr>
<tr>
<td>Planning and development services</td>
<td>2.3</td>
<td>4.9%</td>
</tr>
<tr>
<td>Fire and rescue services</td>
<td>2.2</td>
<td>4.6%</td>
</tr>
<tr>
<td>Other services</td>
<td>0.2</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Total service expenditure</strong></td>
<td><strong>47.1</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The Commission welcomes the additional funding that the Government made available for social care in the last Spending Review. However, local authorities have had to juggle spending and priorities in the context of a tight local government settlement overall and it appears that these additional resources have not found their way to social care budgets in some areas.\(^15\)

Care and support could be delivered more effectively

It is also not clear that overall care costs are managed as effectively as they could be. Responses to our Call for Evidence claim that significant savings could be made through greater investment in early intervention, aids and adaptations, and preventative activities. More joined-up services (such as for crisis response and re-ablement) and approaches (such as for dementia care) also have the potential to deliver value for money across the care and support system as a whole.

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14 Local authority revenue expenditure and financing England: 2009-10 Individual Local Authority Data (Revised).

15 The 2011 Association of Directors of Adult Social Services budget survey found that local authorities were making savings within adult social care totalling £991 million in 2010/11; 23% of this saving was to be achieved through service reduction, and the rest through raising additional income and efficiency improvements.
Demographic change will lead to increasing demand for care and support, putting further pressure on the system

The population of over-65s is projected to grow by 50% over the next 20 years. Within this, the numbers of the very old will grow the fastest, with the number of people over 90 expected to nearly treble over the next 20 years.

There will also be changes in the working-age population, with the expected number of working-age adults with a learning disability rising by around 30% over the next 20 years.16

These trends imply that, as a country, we will need to be spending a greater proportion of our national income on care and support. The Office for Budget Responsibility projects that public spending on long-term care (on unchanged policies) will rise from 1.2% of gross domestic product (GDP) in 2009/10 to 1.7% in 2029/30.

Figure 1.9: Office for Budget Responsibility projections for age-related public expenditure (percentage of GDP)17

<table>
<thead>
<tr>
<th></th>
<th>2009/10</th>
<th>2019/20</th>
<th>2029/30</th>
<th>2039/40</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>8.0%</td>
<td>8.5%</td>
<td>9.4%</td>
<td>10.2%</td>
</tr>
<tr>
<td>Long-term care</td>
<td>1.2%</td>
<td>1.4%</td>
<td>1.7%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Education</td>
<td>6.0%</td>
<td>5.9%</td>
<td>5.9%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Pensions</td>
<td>5.5%</td>
<td>5.3%</td>
<td>6.1%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Public service pensions</td>
<td>1.8%</td>
<td>1.9%</td>
<td>2.0%</td>
<td>1.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22.5%</strong></td>
<td><strong>23.1%</strong></td>
<td><strong>25.1%</strong></td>
<td><strong>26.6%</strong></td>
</tr>
</tbody>
</table>

*Note:* Figures are for the UK. Long-term care covers social care expenditure on working-age and older people and excludes long-term care provided within the NHS, which is included under health.

On top of demographic changes, demand for formal care and support services may be affected by changing levels of prevalence of different conditions. People’s age and certain conditions are closely linked to care and support needs. However, projecting future need for care and support is difficult. Future trends in prevalence of disability in older people are a major determinant of future demand, but also a major uncertainty. There is mixed evidence about what is happening to age-specific prevalence rates of disability in England, and future needs will be affected by changing patterns of disease and treatments.


Projecting future funding requirements will also require making some assumptions about the supply of, and demand for, unpaid care. Evidence suggests that the overall demand for care may rise more quickly than supply. In particular, research suggests that, over the next 20 years, the supply of care by adult children will grow by 13% (assuming unchanging propensity to care), while demand will increase by 55%. Any future reforms must support the contribution made by carers for sustainability and for the benefit of carers and those cared for.

Changes in wealth and society will affect the care and support system

Changing wealth and assets
As a society, we are becoming wealthier. In the future, pensioner incomes should keep pace with earnings across the economy, and more people are likely to have private pensions. This will be augmented as ‘baby boomers’ retire over the next 20 years as many will benefit from generous defined benefit pension schemes (although, as a result of changes to the private pensions market, this trend is unlikely to continue in the longer term).

The proportion of people owning property peaks for those just coming up to retirement. Some 20% of 16–24-year-olds own a property, compared with 79% of 55–64-year-olds and 63% of those aged 85 or older.

If we assume that the cohort of people currently in their 50s do not spend down their wealth any faster than preceding cohorts, our evidence suggests that overall wealth is set to increase among future 70–80-year-olds.

Of course, not everyone will own homes or have significant savings, and it is important that there is additional support for these individuals and families. In particular, those who have a care and support need throughout their lives often have low incomes and do not have the same opportunity to accumulate wealth. Some may have limited assets or income, for example through inheritance or through income accumulated from working, but this is likely to be far less than those who have worked their entire life, owned a home and had the opportunity to save. The median level of total wealth for households headed by an employee is £217,500 compared with only £21,100 for households headed by someone who is sick or disabled. Any reforms to the system need to take into account these different income and asset profiles.

18 Derived from Informal Care for Older People Provided by Their Adult Children: Projections of Supply and Demand to 2041 in England, Pickard L, PSSRU Discussion Paper 2515, 2008.
20 Wealth and Assets Survey 2006–08, Office for National Statistics.
Changing social and technological trends

Changes within the structure of our society also affect the care and support system. For example, women are increasingly participating in the formal labour market, there are increasing numbers of single people, and greater numbers of people are choosing not to have children. These trends could have a significant impact on the availability of informal care, and hence the funding and delivery of care and support.

We can also anticipate that people’s expectations about the quality of care they will receive will also rise as wealth and general living standards increase.

There will also be technological change. Technology is developing rapidly, and is likely to have a significant impact on the way care and support are delivered in the future.

Greater resources will need to be devoted to the adult social care system in the future

A widening gap between demand and spending is unlikely to be sustainable and would lead to rising unmet need, poor outcomes for individuals and potentially greater pressures on the NHS.

Without extra resources, people are not going to get the care that they need, the quality of support is likely to decline and extra pressure will be placed on other services. The Government should ensure that there is sufficient, and sustainable, funding for local authorities so that they are able to manage existing pressures as well as the new requirements as a result of our reforms.

Individuals and families are also going to need to consider how they meet their contribution to care. Many of the people we have spoken to, and who submitted evidence to the Commission, have said that it is not unreasonable that older people should plan and prepare to meet some care costs. We think that the reforms we are proposing will help people to manage that contribution better.
Part 2: The Commission’s proposed funding model
2.1 Detail of the funding model

Summary of our proposed funding model
The core principle of the model proposed by the Commission is a simple one: the state should protect people against the risk of very high care costs by putting a cap on the total care costs that individuals face over their lifetime. Such a scheme would share responsibility between the state and the individual, as those who can afford to contribute would be responsible for meeting the initial share of their costs up to the cap.

To determine whether people are eligible for care and support, and the level of support they need, needs assessments would continue to be undertaken by local authorities. There would also need to be a metering system to measure a person’s progress towards the cap and establish when they qualify for the full state offer.

Under our proposals, means-tested support would continue. However, we are recommending that the current means test should be reformed to give a greater number of people access to some means-tested support and reduce the perverse incentives that exist in the current system.

To support our proposed changes, we are recommending that the Government should ensure deferred payments are available across the country.

We also believe that disability benefits should remain, as they are an important part of the care and support system.

Introduction
This section explains our proposed funding model for adult social care in more detail. It covers:

1. The capped cost model – discussing the level of the cap, how it changes over time and the offer for people who have reached the cap.

3. **Entitlement to state financial support** – explaining how metering would work, our proposed changes to means-tested support and our recommended improvements to the deferred payments.

4. **The role of universal disability benefits** – specifically the rationale for and role of disability benefits, and interaction between benefits and the social care system.

**Figure 2.1: An overview of the processes involved in the new system**

Support for carers

From the outset of our work, we have been clear that any future adult social care system would need to be resourced through a combination of state, private and unpaid care. Our challenge was to try and set a reasonable balance between the three. We believe that by improving the overall funding system we can achieve benefits for carers, but we also know that there are specific changes that could help. Over the course of our work, we have spoken to carers and their representative organisations. Three particular issues were consistently raised – improved carers’ assessments, better information and advice, and support to work. We agree that all these areas are important and need to be improved.
A better funding system is better for carers
Evidence suggests that better services for the cared-for bring real benefits to carers. By providing state-funded care to those with high lifetime needs, we believe there would be better support for carers and families. Removing fear and uncertainty by capping costs will make it easier for people to make the choice to buy care services rather than relying on their families. Our recommendations for a national eligibility and assessment framework, with portability of assessments, will offer greater support and clarity to families as well as the cared-for.

Carers’ assessments (more details can be found later in this section)
We are supportive of the Law Commission’s recommendations that carers should have new legal rights to assessments and services. We believe that these assessments should build on the desired outcomes for adult carers which are outlined in the national Carers’ Strategy (and its refresh), and that assessment should be better aligned with that of the cared-for person.

Information and advice for carers (see Section 3.2 on planning and preparing)
Better support for carers must be a key component of an improved information and advice service. Carers need to be signposted to people and organisations which can provide support – both as they begin to care and at all stages in the caring pathway.

Support to work (see Section 3.1 on the wider care and support system)
The reformed adult social care system should enable carers to undertake paid and unpaid work, should they want to. We encourage the Government to push forward with efforts to encourage and support carers to work, as carers make a valuable contribution to the economy. But we also believe it is in an employer’s interest to be flexible when considering the needs of someone with caring roles. Better provision of information and advice could also play a valuable role here. We understand that many carers give up employment prematurely because of an initial crisis and do not realise the full implications of doing so. For example, many may be unaware of their legal right to request flexible working arrangements.

1 What are the most effective and cost-effective service for informal carers of older people?, Pickard L., Research in Practice for Adults, 2006.
3 Evidence from the Standing Commission on Carers provided to the Commission, June 2011.
1. The capped cost model

The funding system that the Commission is proposing is based around a ‘capped cost’ model, with additional means-tested support for those who are less able to make their contribution.

Under this model, the state limits the amount of care that a person is responsible for funding themselves over their lifetime. Initially the individual is responsible for the full cost of care (if they can afford it), but once they have faced a certain level of cost, the state pays for the rest of their care. We believe that this is the best approach to sharing responsibility between individuals and the state. The state in effect pools risk by setting a limit on the costs that anyone may have to make. This would remove the open-ended financial risk that people currently face. It would offer everyone greater peace of mind, taking away the fear of very high care costs. The rationale for the capped cost approach is set out in more detail later in Section 3.3.

The level of the cap

We believe the cap should be set at a level that realises the benefits set out above, while delivering value for money for the state. We believe the level of the cap should be different for older people and younger adults, as the latter have had less opportunity to accumulate wealth and plan and prepare for meeting those care needs.

*Older people*

People who develop a care need in later life have often had the opportunity to accumulate significant assets. These assets may be in the form of savings or property, with the latter being where many people in the UK hold most of their wealth. In addition to their assets, many older people have pension income which could cover some of their care costs. It is our assessment that the level of the cap should have reference to typical property values and typical incomes for older people.

We have considered carefully the level at which the cap should be set and have concluded that it should be between £25,000 and £50,000. A cap set outside this range might not meet the criteria we agreed with the Government. For example, we do not think that a cap above £50,000 would offer sufficient protection to the assets of lower income and lower wealth groups and would not be fair; while a cap below £25,000 would have many of the same drawbacks as a full social insurance model which we do not view to be sustainable or resilient in the longer term. Figure 2.2 shows the maximum asset depletion that individuals might face as a proportion of their assets under different levels of the cap.

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4 As we discuss later in this chapter, individuals will still be responsible for making a contribution to general living costs, but this will be a fixed amount.
Figure 2.2: Maximum possible asset depletion under our core proposals for people who enter residential care and have lifetime care costs of £150,000

![Graph showing asset depletion under different systems.]

Source: Commission analysis

Given this, in our view a cap of £35,000 is fair and realistic. We have used this as the figure for the cap throughout this report. Figure 2.3 shows how this compares with wealth and incomes.

Figure 2.3: The cap compared to typical levels of wealth and income for single women aged 75-84 in England

![Bar chart showing wealth and income levels.]

Sources: Wealth and Assets Survey 2006–08; DWP Pensioners’ Incomes Series, 2009/10

5 This chart assumes residential care costs of £28,600 p.a. and individual income just sufficient to cover a contribution to general living costs of £10,000 p.a.

6 Wealth refers to savings and housing assets.
We understand that not every older person has had the same opportunity to accumulate assets, and people’s ability to make such a contribution will vary due to a range of factors. We therefore propose not only retaining the means-tested support offered by the current system, but extending it to cover more people with lower incomes and wealth, so that those with less wealth make a smaller contribution towards their care costs. We also believe there may be a case for more consistent treatment of assets between different care settings. The proposed modifications to the means test are discussed in detail later in this section.

**Younger adults**

To maximise clarity and minimise arbitrary boundaries, we are keen to have one overarching system. Having more than one system could lead to unfair outcomes for different groups. For example, were there different systems for people above and below the current state pension age, a 64-year-old man and a 65-year-old man with similar levels of need and the same financial position would have to make very different levels of financial contribution and have very different outcomes. This does not seem sensible, nor is it equitable.

We therefore think that adults who develop an eligible care and support need before they reach the state pension age should be assessed in broadly the same way as an older person. If they have significant personal wealth or income, they should be required to make a contribution towards their care costs, but what is viewed as reasonable will be different for people who develop care needs at different ages.

A majority of people will develop care needs as they become older and we believe it is reasonable to expect people to plan and prepare to meet some of these costs. However, it is much less likely that a person will develop a care need while they are still young, so it is less reasonable to expect people to prepare for this eventuality. People who develop care needs earlier in their lives have also had fewer opportunities to build up their income and savings that could be used to pay for care.

Figure 2.4 shows the age profile of younger adult service users. Those with learning disabilities are significantly younger on average than those with physical disabilities.
Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support

**Figure 2.4: Number of younger adults receiving state-funded social care, by age and client group**

![Graph showing number of younger adults receiving state-funded social care by age and client group](image)

Source: Commission analysis of data from a 2005 survey by Tribal Secta and Community Care Statistics, Social Care Activity, England, 2009-10 (further release), The Information Centre

**Figure 2.5 shows the wealth of people in different age groups. People accumulate wealth throughout their lives, so the median wealth of those aged 25–34 is around £30,000 per person compared with around £175,000 per person for those aged 65–74. The decrease in wealth for each subsequent group over the age of 65 may in part be due to people spending their savings in retirement. However, it will also be caused by a cohort effect: in recent years, each generation has been richer than the last.**

**Figure 2.5: Distribution of net household wealth per adult, by age (net financial, property and private pension wealth)**

![Graph showing distribution of net household wealth per adult by age](image)

In general, those who develop care needs earlier should be expected to contribute less and we therefore think the cap should be tiered and a different cap applied at different ages.

We think a tiered approach could work as follows:

- People who reach adulthood with eligible care needs, many of whom will have been born with a disability, should not be expected to contribute towards their care costs. The cap would be set at zero for this group, and they would receive free care throughout their lives. This provides scope to simplify and streamline support, especially at the key time of transition from childhood to adulthood – often a time of uncertainty and anxiety for individuals and their families. We believe that a guarantee that the state would continue to fund care in full would be reassuring to many families.

- Anyone developing an eligible care need before a defined age – we think this should be around 40 years of age – would also face a zero cap. We do not think that people can realistically be expected to save to cover the costs of developing a care need at this stage of their lives, and most will not have accumulated significant assets. People may still be paying off debts, including mortgages, and could have young families.

- Those who develop a care need after the age of, say, 40 would be expected to make a contribution towards their costs, and the cap should increase with age, with those developing care needs after the state pension age making the full contribution of £35,000. The cap could rise at £10,000 per decade, so that a 40-year-old would contribute £10,000, a 50-year-old £20,000, a 60-year-old £30,000 and a 65-year-old £35,000.

We have chosen 40 years of age as the point at which the cap starts to increase from zero as by this point, as Figure 2.4 shows, many people will have built up some wealth. However, it will be for the Government to make a judgement on exactly how they wish to implement such a tiered system.

In the future, the financial services sector could also develop products that offer protection against the cost of care for those who develop care needs earlier in their lives. For example, critical illness policies could pay out lump sums to cover the costs an individual faces should they develop a care and support need at a given point in their life.

Some disabled younger adults have large funds resulting from compensation payments for accidents that led to their disability. Because of the current funding arrangements for social care these funds are used to pay for social care needs. The Government will need to consider how the cap would operate for younger adults in this position.
Responding to different care profiles
The contribution that each person makes should be determined by the age at which they first develop an eligible care need, even if this need is only temporary, it may affect their ability to build up income and savings subsequently. Care needs can also be episodic, and this is particularly the case for those who develop needs earlier in their lives.

As the capped cost system is designed to protect people against high lifetime care costs, we think that all episodes should count towards the cap, regardless of when they occur and whether they relate to the same underlying condition.

How the level of the cap should change over time
We have said that the cap should be set at a level that reflects what it is reasonable for most people to expect to pay in later life. Over time, inflation would mean that a care cap of £35,000 would become less in real terms. Furthermore, incomes may change in real terms (in general, earnings have risen faster than prices). It is therefore important that the cap is adjusted to take account of these changes, so that it maintains the same level of affordability over time. Our suggestion is that the cap is uprated yearly on the same basis as the basic state pension.

The Government may also want to make specific changes to the level of the cap, within reason, if it thinks that the state should take a greater or lower proportion of care costs. It is important that the overall model is stable, so people have some certainty that allows them to plan. However, there is flexibility over time. To decide on the most appropriate level for the cap, the Government might choose to ask an independent body to review periodically the overall level of the cap. If the Government decides to ask an independent body to review the state pension age, it might also ask the same body to review the level of the cap. This would help build public confidence and reduce uncertainty, thereby supporting the financial services sector in designing and pricing products, but also helping individuals and families in their financial planning.

The offer for people who reach the cap
The costs to be covered by the local authority once someone has reached the cap would be based on the typical local authority package for that level of care in that area. If the individual chooses more expensive care, then the local authority will not meet those more expensive costs, though individuals should be able to ‘top up’ their care through additional contributions should they wish to do so.

On meeting the cap, people would not be required to contribute towards the cost of their care, whether out of their income or from their assets. We believe it is very important that income and assets are
treated in the same way, both to ensure fairness and to avoid creating perverse incentives. If people who had reached the cap were expected to contribute towards their care from their income (so that the cap was in effect an asset protection scheme), there would be a strong advantage in holding wealth in the form of assets rather than using it to produce income. It would mean, for example, that individuals who had used some of their wealth to purchase an annuity would potentially be much worse off than individuals with the same wealth who had not annuitised – creating unfairness and a strong incentive not to annuitise.

2. Assessing care needs
The social care system aims to help people to meet their practical, social and emotional needs and achieve the outcomes they want from their life. The system also supports those who find themselves in vulnerable circumstances. An assessment system is required that determines different needs, and the level of support that is required to meet those needs.

Under the capped cost system, assessment would serve two purposes:

- for those who qualify for local authority funded care, it determines what state support they are provided with; and

- for those who do not yet qualify, it allows their care needs to be metered so that they know when they reach the cap.

Assessing eligibility for care and support
A system of assessment has to be able to differentiate between varying levels of need, and to do so it needs an appropriate measurement scale.

A range of assessment scales is used in health and social care systems within the UK and elsewhere in the world, and these scales vary in their complexity and focus. The scale currently used in the social care system in England is called Fair Access to Care Services, or FACS. It is our view that there are problems with the current FACS scale, and we believe that it should be replaced in the future with a more objective scale – one which can be the basis of a clearer, fairer and more coherent social care system.

7 The FACS guidance was replaced by Prioritising Need in the Context of Putting People First: a whole system approach to eligibility for social care – Guidance on Eligibility Criteria for Adult Social Care, England 2010, Department of Health, 2010. However the system is still commonly referred to as FACS. Given this, we are continuing to use the term FACS in our report.
Assessment scales

FACS assesses social care needs across a number of dimensions (health and safety, autonomy, management of daily routines, and involvement in family and wider community life) and decides whether a person’s needs in each dimension mean that they face low, moderate, substantial or critical risk to their independence. Local authorities currently have the freedom to set an eligibility threshold at one of these levels, and they then have a duty to meet all of a person’s needs that they assess as eligible, provided that the person is entitled to means-tested support.

An extract from the Department of Health’s guidance on FACS

The eligibility framework is graded into four bands, which describe the seriousness of the risk to independence and well-being or other consequences if needs are not addressed. The four bands are as follows:

**Critical – when**

- life is, or will be, threatened; and/or
- significant health problems have developed or will develop; and/or
- there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or
- serious abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out vital personal care or domestic routines; and/or
- vital involvement in work, education or learning cannot or will not be sustained; and/or
- vital social support systems and relationships cannot or will not be sustained; and/or
- vital family and other social roles and responsibilities cannot or will not be undertaken.

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Substantial – when
- there is, or will be, only partial choice and control over the immediate environment; and/or
- abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or
- involvement in many aspects of work, education or learning cannot or will not be sustained; and/or
- the majority of social support systems and relationships cannot or will not be sustained; and/or
- the majority of family and other social roles and responsibilities cannot or will not be undertaken.

Moderate – when
- there is, or will be, an inability to carry out several personal care or domestic routines; and/or
- involvement in several aspects of work, education or learning cannot or will not be sustained; and/or
- several social support systems and relationships cannot or will not be sustained; and/or
- several family and other social roles and responsibilities cannot or will not be undertaken.

Low – when
- there is, or will be, an inability to carry out one or two personal care or domestic routines; and/or
- involvement in one or two aspects of work, education or learning cannot or will not be sustained; and/or
- one or two social support systems and relationships cannot or will not [be] sustained; and/or
- one or two family and other social roles and responsibilities cannot or will not be undertaken.
FACS is very broad in its scope and allows social care professionals to take into account a wide range of factors when making their assessments and judgements about the level of risk that the person in question faces. While this approach ensures that assessors are able to look at all relevant factors, it is widely felt to pose significant problems.

Many people have told us, through our Call for Evidence and in our meetings with stakeholders, that the FACS criteria are highly subjective and leave significant discretion to the assessor. This creates scope for considerable variability, both within and between areas. We believe that the reformed social care system needs to constitute a clearer national offer, and that this would be difficult with FACS.

FACS also makes it difficult to achieve the clarity and consistency that we believe are important in any reformed system. As FACS criteria are open to interpretation, it is difficult for someone with a social care need to know whether they are likely to be eligible for state support. It is also difficult for government, either centrally or locally, to ensure that everyone is treated fairly and consistently. In addition, we believe that FACS is a blunt tool for adjusting the generosity of the system. For example, an Audit Commission report from 2008 found that the FACS level that local authorities used as an eligibility threshold had little effect on their average social care spend per older person in their area.9

As a result of these concerns, the Commission is clear that lasting reform will need a new assessment scale – one which is easier for users to understand and does more to ensure fairness and consistency. A new scale will also need to cover a full range of issues. There are risks to independence and well-being relating to different areas of life, including health and emotional well-being; protection from harm; education, training and recreation; the contribution made to society; and securing rights and entitlements.10 Any new assessment scale will need to ensure that all of these areas of full captured.

We believe that this should be taken forward quickly. However, it is not obvious to us what this scale should be (and a suitable scale may not yet exist). Given this, we think the Government should urgently review the social care assessment scale, working with local government and third-sector organisations representing users and carers and drawing on

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10 The Law Commission has recommended that a new statute should establish that the overall purpose of adult social care is to promote or contribute to the well-being of the individual. The outcomes set out above are those specified by the Law Commission as those to which the well-being principle must be directed.
academic research and international experience, with a view to moving towards a more objective scale that gives more clarity to users and fairer and more consistent outcomes.

**Setting thresholds nationally**

A review of the assessment scale will take some time, so in the interim we believe the Government should make what improvements it can while retaining FACS. One improvement that we believe should be made is to standardise the level at which local authorities set their eligibility thresholds by setting a national minimum offer. This would not ensure that all people would be treated equally, but it would make the system clearer and signal the move towards a more national offer.

We therefore believe that it would make sense to **standardise FACS eligibility nationally at ‘substantial’, pending a full review of the assessment scale.**¹¹ Local authorities, however, would be free to be more generous if they wished to. Most local authorities (78%)¹² currently set their thresholds at ‘substantial’ with the others having either higher (4% at ‘critical’) or lower thresholds (15% at ‘moderate’, 3% at ‘low’).

When reviewing the social care assessment scale, the Government should consider what the most appropriate level to set the eligibility threshold would be in the new system, noting that it should continue to be national.

**Portability of assessments**

Needs assessments should also be portable in the future, so that a person receiving local authority support has greater freedom to move across local authority boundaries.

Under the current system, people making such a move would lose their support until they were reassessed, and this prevents some people from moving. In future, **people moving from one local authority to another should retain their needs assessment, and the receiving local authority should have a duty to meet all eligible care needs until they are able to reassess that person.** The Law Commission’s recommendations on reforming the social care statute also set out proposals for facilitating portability. The proposals we set out here are consistent with these recommendations.

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¹¹ The recommendations of the Law Commission to reform the social care statute include a recommendation which would allow governments to set eligibility at a national level in England or in Wales, should either government wish to do so.

¹² Information from an Association of Directors of Adult Social Services survey of English local authority adult care budgets for 2011/12.
Assessments for carers

When assessing a person’s social care needs, local authorities take into account whether they have access to unpaid care from family or friends. However, it is important that caring does not become too great a weight on the carer, or become detrimental to their own quality of life and well-being.

To support carers in the contribution they make, we strongly believe carers, just like the cared for, should be properly and fairly assessed. Carers need to be better supported by clear access to services, with the aim of ensuring that caring is manageable and sustainable. We believe that carers should be fully consulted about the support they need, to ensure that the demands placed upon them are not too great. For example, the needs of the carer in relation to work (paid or unpaid), leisure and education should be taken into account.

The Law Commission\textsuperscript{13} has proposed that carers should have new legal rights to services. Under the proposals, there would be a new social care statute which would set out a single and stand-alone duty to undertake a carer’s assessment. Local authorities would use a framework to set their eligibility criteria and would then apply those criteria to determine a carer’s needs. The local authority would be required to meet the eligible needs of carers, either by providing services to the cared-for person or carers.

The Commission strongly supports this direction of travel. In setting such a framework for carers, the Commission believes that it is important to embed certain principles, building on the desired outcomes for adult carers described in the national Carers’ Strategy (and its refresh).\textsuperscript{14} These are that carers should:

\begin{itemize}
  \item be respected as expert care partners, so that a carer’s contribution is fully valued;
  \item be treated with dignity and respect;
  \item have access to integrated and personalised services to support them in their caring role, with assessments taking into account personal preferences and the level of care the carer is able to offer;
\end{itemize}

\textsuperscript{13} \textit{Adult Social Care}, Law Commission, 2011.

\textsuperscript{14} \textit{Carers at the heart of 21st-century families and communities}, HM Government, 2008 and the strategy’s refresh in 2010.
• be able to have a life of their own alongside their caring role, including entering or returning to paid or unpaid work, education, training and leisure;

• be supported adequately so they are not forced into financial hardship by their caring role; and

• be supported to stay mentally and physically well.

We believe it is important that the assessment uses a whole-family approach, for the benefit of both the individual who needs support and those who are supporting them. Allowing both parties to identify their own needs and desired outcomes is beneficial to the well-being of all concerned and is likely to lead to care which can be effectively sustained. We also agree with the Law Commission, that the assessment should be proportionate – in line with the wishes of the carer at that time.

We have been told that it can take many weeks before a carer’s assessment is completed, and then nothing can come of it. **We recommend that in future, assessments of carers and individuals happen at the same time, but are completed separately, to make sure carers feel able to speak openly about their needs.** Assessment should also be repeated regularly, and we suggest carers are consulted yearly on whether they need a further assessment – preferably at the same time as the person with the care need is assessed. **Carers’ assessments should also be portable.**

**Scope of the care package**

When someone has eligible care needs, the state needs to determine what care package is required to meet those needs. In the future, if someone is eligible for financial support from the state we expect the majority of people will receive this support via a personal budget or a direct payment.

In the system proposed by the Commission, those with eligible needs but who fail the means test would have the value of their support metered, so that when they have been exposed to a certain amount of cost the state can step in. Given this, it is important to be clear what is and is not covered by the care package. Two issues are of particular relevance – unpaid care and general living costs – and these are discussed below.

**Unpaid care**

As with eligibility, the care package that someone is entitled to should continue to take into account the level of unpaid care that is available. However, as we stated earlier, the expectations placed on carers must be reasonable and not detrimental to their own health and well-being. An improved carer’s assessment process should help to achieve this.
General living costs

It is our view that the state has a role in supporting people in meeting exceptional care costs, as these costs are unpredictable and there is a risk that they could be very high. However, general living costs, such as food and accommodation, are more predictable, and we believe that these should continue to be the responsibility of the individual (supported by the social security system), whether or not they have a care need.

People receiving care at home or in the community already have responsibility for their general living costs. A residential care package, however, includes all of these costs. We believe that it follows that a person receiving state-funded residential care should, provided they can afford to, make a contribution towards the cost of the care home placement to reflect their general living costs.

We think that the contribution should be a fixed amount across the country – as this is a fair and simple approach. Setting a limit on the amount that people have to contribute towards general living costs means that it would not be possible to charge more for care and claim that it is for general living expenses. This would add greater transparency to the system.

The level of contribution to general living costs

Overall we believe that the size of this contribution should be based on what people could reasonably be expected to afford and what they would expect to pay for general living costs if they were not in residential care. People of any age who are not able to afford the contribution would continue, as now, to be eligible for support from the state.

Older people

We have considered a range of figures between £7,000 and £10,000 p.a. (and the different costs for these figures are presented later in the report). For the purposes of our analysis and modelling, we have used £10,000 p.a. or around £192 per week for older adults.

The Guarantee Credit guarantees a minimum annual income for those over state pension age of £7,142. The median income for single people over state pension age in 2009/10 was £11,284 which, after accounting for the Personal Expenses Allowance (PEA), would mean that just over half of all people could afford to make a contribution of £10,000 from their income. We therefore suggest that, for older people, government sets a contribution towards general living costs of between £7,000 and £10,000.

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15 The amount that, in assessing a resident’s ability to pay for their care home place, the local authority is required to ensure is retained for personal expenses.
People of working age

The Government will need to consider the level of the contribution made by people of different ages – and what is appropriate and affordable (as for the cap).

The social security system, on average, provides less means-tested state support towards living costs to younger people than to people over state pension age, reflecting the fact that older people have fewer opportunities to generate additional income through employment. This, coupled with the shorter time that younger people requiring support would have had to build up assets, suggests that they should make a smaller contribution to general living costs in a residential setting than older people.

Deciding the value of a care package

Local flexibility

To balance local flexibility effectively with a clear national offer, we think it is important for the Government to ensure that there will be sustainable funding for local authorities. Local authorities need to be able to manage the existing pressures as well as the financial risk associated with the additional requirements resulting from our proposed reforms.

In order to tailor packages to local needs and provide local authorities with flexibility, under our proposals local authorities will be able to decide the size of the social care package an eligible person requires.

As now, the local authority should have a duty to meet all of a person’s eligible needs but will have the freedom to decide how it does this.

Under our proposed model, individuals and carers would be able to take their assessments with them to a new local authority and continue to receive care until they are reassessed. However, local authorities would still need to reassess to determine the care package and support available. As a result of the reassessment an individual’s (and a carer’s) package of support may change.

Resource allocation systems

Most local authorities currently use a resource allocation system (RAS) to help them work out how much care a person is likely to need. There is not a national system in place, although many local authorities use similar systems.

A RAS works by assessing a person’s care needs using a questionnaire, which gives each person a numerical score. The scores for people entering the care system are compared with the scores of existing care
recipients, and an estimated care package cost is assigned based on the cost of care for other people with similar scores. The local authority then designs a care package for that person, and aims to meet their needs for the same cost to ensure fairness with respect to other care recipients. Exceptions are made when it is not possible to fully meet the person’s needs at the same price.

Under the Commission’s proposals, local authorities are likely to have to assess more people, as more would come forward to begin their progress towards the cap. We envisage that similar systems would continue to be used, and that local authorities would be able to build on and improve the systems that they have in place.

3. Entitlement to state financial support

Under the Commission’s proposals, a person with eligible care needs would be entitled to financial support from the state in two situations:

- the capped cost system entitles a person to state support once they have taken responsibility for a certain amount of care themselves; and
- the means-tested system provides state support earlier for those who can less well afford to make this contribution.

In this section, we first discuss our recommended approach for how to ‘meter’ care needs and then outline our proposed changes to the means-tested system.

**Metering care needs**

Under the capped cost system, individuals will initially be responsible for their own care costs. Once they have reached the cap, the state would then cover all of their future care costs. The system therefore needs a way of measuring or metering the amount of care that an individual has paid for (or required), so that the local authority knows when care costs become its responsibility.
‘Notional spend’ should be metered

There are a number of different views that could be taken as to what ‘currency’ should be used to meter the amount of care for which a person takes responsibility.

We have considered three options.

• The first option is to meter individual spend on care. This would need to be subject to a maximum level of expenditure that the state thinks is appropriate for an individual’s care needs, to prevent people over-consuming in order to reach the cap more quickly. However, in practice this would be difficult to administer, as the state would need to verify that the expenditure claimed by an individual was indeed spent on care. The additional bureaucracy that this would require makes this option unattractive.

• The second option is to meter the length of time for which a person has had sufficient care needs to make them eligible for the state system. This has the advantage of being easy to administer and simple to understand. However, this option would disadvantage those with more intensive care needs who, over any given period of time, could spend significantly more on care than those with less intensive needs. A fair social care system should give the most support to those with the greatest need and metering on the basis of time could undermine this.

• The third option is to meter ‘notional spend’ – that is, the amount of money that the local authority assesses is required to meet an individual’s needs, based on a full needs assessment. As with metering time, this option is relatively simple to administer, given that a system of needs assessment is already in place. An advantage of this option is that the needs on which a person is metered are the same needs that would be met once that person reaches the cap and, as with metering actual spend, it also ensures that those with more intensive needs are not disadvantaged. The Commission believes that the only suitable way of deciding when a person has reached the cap is to meter notional spend.

All notional spend should be metered, regardless of who actually pays

Even when a person is paying for their own care, the state supports them financially, through the state pension, universal disability benefits and, for those who cannot afford to pay their care costs in full, means-tested support. We have considered whether any direct financial assistance that the state provides should be excluded from the amount metered, so that the amount counted reflects the actual financial costs which the person has borne, i.e. their out-of-pocket expenses.
If only the individual’s out-of-pocket spend is metered, then an individual who is receiving support under the means-tested system would, if they continue to need care for long enough, ultimately make the same contribution as a wealthier person with similar needs. The net effect of the means-tested system would therefore be that they contribute more slowly, rather than contributing less overall, so excluding state contributions from the meter would make the system unfair for those on low incomes.

An individual’s entire notional package should therefore be metered, regardless of how (or if) the costs are met.

*The meter needs to be portable*

As with needs assessments, the meter should give people peace of mind about moving between local authorities without penalty. The amount of social care that a person has taken responsibility for, and which has therefore accrued to their meter, should remain with the person if they move to another local authority. Government will need to consider how this is best implemented.

*Means testing*

Before they reach the cap on care costs, people would be expected to take responsibility for meeting their care and support needs. However, people with low means may not be able to afford this contribution in full, and they should receive additional support. It is therefore important for the new system to retain means-tested support, although we are proposing some reforms to the current system to make it fairer and remove some of its perverse incentives.
Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support

Summary of proposed reforms to the means test

The current means test is the starting point for the means test in the reformed system, but we are recommending some important changes to make it fairer and to remove some of its perverse incentives.

For those in residential care, we are recommending that the upper asset threshold should be increased from £23,250 to £100,000. Tariff income would be calculated as under the current system on assets between £14,250 and £100,000. People with assets above £100,000 would receive no means-tested support.

The existing deferred payment scheme for those who are in residential care and are not receiving full state support should be available across the country – so that everyone who wants to avoid selling their home can do so. A universal scheme should charge people a reasonable rate of interest so that it is cost neutral to local authorities and does not create incentives for people to apply for deferred payments where they are not needed.

Once the cap is in place, we believe that a government might in future want to consider changing the way that housing assets are treated by the means test by including housing assets in the domiciliary means test as well as in the residential means test. This would result in a consistent means test for social care across care settings. The Government could also consider changing the way that income is treated in the means test to make the system fairer and encourage people to save. We think that introducing a taper into the system would mean that more people see the benefits of having some savings.

Each of these recommendations is explained in detail below.

Upper asset threshold for residential care

Under the current means-tested system, people with assets of less than £14,250 only pay towards their care what they can afford out of their income, while people with assets greater than £23,250 receive no support.

People with assets between these values are expected to make a contribution out of their assets, which is calculated by assuming that they can afford an extra £1 per week for every £250 of assets they have above the £14,250 threshold (this is known as ‘tariff income’). This offers
little protection to homeowners as almost everyone with a home fails the means test: median housing wealth among over-65 property owners is £160,000;¹⁶ and 95% have housing wealth over £60,000.

The removal of all support from people with assets greater than £23,250 also creates a ‘cliff edge’: a person with £23,000 of assets will get some of their costs paid, while a person with £24,000 will receive no support at all. People who have made greater provision for their care are therefore required to spend down their assets before they receive any support from the local authority, while those who have not saved get their care for free. As well as being perceived as unfair, this acts as a disincentive for people to save.

The approach to asset-testing for social care contrasts with the approaches taken for other elements of the social security system. In particular, the value of assets disregarded is higher than in other systems: for domiciliary care this makes the means test relatively generous. However, since housing assets are included for those in residential care, the system is relatively ungenerous for most people in care homes. There is a further contrast with the Pension Credit system, which does not set an upper limit for eligibility, but rather applies tariff income to everyone.

Figure 2.6: Asset tests in social care and elements of the social security system

<table>
<thead>
<tr>
<th>Assets included in test</th>
<th>Council tax benefit</th>
<th>Housing benefit</th>
<th>Pension Credit</th>
<th>Social care system</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Financial assets only</td>
<td>Financial assets only, Not paid to those with housing assets.</td>
<td>Financial assets only</td>
<td>Financial assets for domiciliary care, financial plus housing in residential care</td>
</tr>
<tr>
<td>Amount disregarded</td>
<td>£6,000</td>
<td>£6,000</td>
<td>£10,000</td>
<td>£14,250</td>
</tr>
<tr>
<td>Tariff income rate</td>
<td>£1 per week per £250</td>
<td>£1 per week per £250</td>
<td>£1 per week per £500</td>
<td>£1 per week per £250</td>
</tr>
<tr>
<td>Upper limit for eligibility</td>
<td>£16,000</td>
<td>£16,000</td>
<td>None</td>
<td>£23,250</td>
</tr>
</tbody>
</table>

The Commission recommends that the £23,250 threshold should be increased to £100,000 for those in residential care. We suggest this could be increased annually in line with the basic state pension. This would ensure that state support extends to a reasonable level in the wealth distribution, and enables less wealthy home owners to receive means-tested support. It would also improve incentives to build up a stock of assets, in housing or otherwise, and reduce incentives to play the system by trying to dispose of housing assets earlier in life should residential care become necessary.

Figure 2.7 illustrates the effect of the change. It shows state support p.a. received by an individual in residential care before they reach the cap, by their level of assets. Instead of a cliff edge at £23,250, the removal of state support would be much more graduated, ensuring that people who own their own homes with values in the bottom quintile of the housing wealth distribution get some state support in making their contribution and do not have to risk losing all their assets before they reach the cap.

**Figure 2.7: The effect of extending the upper asset limit on the amount of support received by an individual towards their care costs in residential care**

Source: Commission analysis

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17 This chart assumes that the person’s income covers general living costs only, and that care costs are £18,600 p.a.
Case study: How the reformed means test would work

An older woman had arthritis and mobility difficulties which meant that she required a domiciliary care package of £100 per week after her husband died when she was 78. This was part funded by the state as she had a weekly income of £215 and savings of £3,000. Her condition worsened and at age 80 she moved into a residential care home for the final three years of her life.

Under the current system
On moving into the home, she had to use her savings and sell her house worth £75,000 to fund her care. She paid the full £28,500 p.a. using the money from her house, her pension income and disability benefits. She would be able to keep £22,000.

Under our reformed system
Her domiciliary care package funded by her local authority would have meant that £10,000 had already been contributed towards the cap by the time she moved into the care home. At that point, her housing assets would be taken into account in the means test but with her house value falling below the upper asset threshold of £100,000, she would receive a contribution from the state of around £6,500 per year and so would pay a reduced rate of around £12,000 p.a. from her assets, along with a contribution of £10,000 from her income for general living costs. She would reach the cap after a year and a half in residential care, and for the remaining year and a half would contribute only towards her general living costs. She would be able to keep £62,000 of her wealth.

Interaction between the cap and the means-test threshold
Such a change to the safety net has an important interaction with the capped cost element of our reforms.

If a cap of £35,000 were to be applied together with the current means test, this would result in almost all homeowners paying the full costs of residential care until they reached the cap. For those with the lowest level of housing wealth this could mean spending up to almost 60% of their assets. This is a significant improvement when compared with the current system in which people can lose almost 90% of their assets paying for care. However, the impact is still felt disproportionately by those in the lowest wealth quartile.
By extending the means test with a threshold of £100,000 in combination with a £35,000 cap, there is greater protection for those with lower housing wealth. As shown in Figure 2.8, the combination of the capped cost model and the extended means test would ensure that no one going into residential care would have to spend more than 30% of their assets on their care costs.

**Figure 2.8: Maximum possible asset depletion for people who enter residential care and have lifetime care costs of £150,000**

![Figure 2.8: Maximum possible asset depletion for people who enter residential care and have lifetime care costs of £150,000](image)

Source: Commission analysis

**Housing assets and the means test**

When assessing a person’s assets, the system treats those in residential care differently from those receiving care in their own home. For people in residential care, the value of their house is included (unless they have a spouse, a relative over 60 or a child under 18 still living in the property), but for those in domiciliary care it is not. This creates financial incentives for people to stay in their own homes, even if a care home placement would better meet their needs. Meanwhile, local authorities have a financial incentive to place homeowners in residential care. The current system is also unfair, as those who have no choice but to go into a care home – often the most vulnerable people with the greatest needs – usually have to pay the full cost of their care, even if that means selling their homes, while most people receiving domiciliary care can receive support from their local authority.

18 This chart assumes residential care costs of £28,600 p.a. and individual income just sufficient to cover a contribution to general living costs of £10,000 p.a. Housing wealth percentiles relate to homeowners only.
The UK also has a relatively high concentration of wealth in housing: the principal residence makes up 74% of UK households’ total assets, compared with 64% in Germany and Canada, and around 50% in the US. Use of housing assets in care is not uncommon. They are already drawn upon for residential care in England; in Ireland, residents receiving care in a nursing home pay 5% of the value of any assets p.a. (in excess of £36,000) in user fees (which can be deferred); and in the Medicare system in some US states, charges are made through an estate recovery. The inclusion of housing assets in means testing ensures that all types of wealth are treated consistently, and avoids creating incentives for people to hold more wealth in housing than they otherwise would, so that they do not pay for care.

In the light of these observations, we believe there may be a case for housing wealth to be included in the domiciliary means test in the longer term (once the cap is in place).

We know that making such a change would be difficult. Our deliberative research revealed that using housing assets to pay for care is a very emotive issue. Many people, while accepting that they need to make an individual contribution, are currently reluctant to have to use housing assets to do so. However, once a cap is in place we believe that it would be easier for people to think about using their housing assets differently, as most would only have to use part of the value of their house (a cap of £35,000 is less than a quarter of the median house price in England, and some couples may need to contribute up to £70,000).

**Treatment of income in the means test**

Currently, people in state-funded domiciliary care make a financial contribution based on their income and liquid assets. Every pound of assessable income above a minimum income threshold of around £170 per week can be taken in charges towards the cost of care for older people. This amounts to a 100% marginal tax rate on income and, as well as being seen as unfair (as people who have saved for retirement and have to spend those additional savings on care charges could be left with the same amount of income as those who did not save), it reduces incentives for people to take measures to increase their pension income or to make provision to cover their care costs.

The incentive problem is pronounced in domiciliary care where the majority of people receive means-tested support. This means that even those with substantial housing wealth who could afford to boost their incomes when they have care needs, for example through releasing housing equity, are disincentivised from doing so.

---

Figure 2.9 shows the effect of this system on people with care costs of £150 per week: those with incomes of £300 per week are left with the same income after charges as those with incomes of £170 per week.

**Figure 2.9: The effect of the current income test on people in domiciliary care with care costs of £150 per week, by income**

![Graph showing effect of current income test](image)

Source: Commission analysis

Similarly, in residential care, individuals facing charges towards their care pay those charges above a minimum threshold – the PEA of £22.60 per week. Those who have saved for retirement and have to go into residential care are left with the same amount of weekly allowance as those who have not.

In contrast, the benefits system typically withdraws support gradually as a person’s income increases, to ensure that people have incentives to earn and that those who work are better off than they would have been were they not in work. This gradual withdrawal of support is known as a taper, and in not applying a taper the social care means test is at odds with the social security system.

**Figure 2.10: Key tapers in the social security and social care systems**

<table>
<thead>
<tr>
<th></th>
<th>Council tax benefit</th>
<th>Housing benefit</th>
<th>Pension Credit</th>
<th>Social care system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective marginal tax rate on income</td>
<td>20%</td>
<td>65%</td>
<td>40% on income within the Savings Credit thresholds</td>
<td>100%</td>
</tr>
</tbody>
</table>

A taper could be applied to the social care means test, so that for every pound of income above the minimum in each care setting, only a certain
proportion would be taken as a charge. This would make the system fairer for those who have saved and smooth out inconsistencies in the system – see Figure 2.11 below for what a taper of 65% would look like in domiciliary care.

For those receiving home care, this would effectively act as a co-payment by the state towards the package as a whole, as well as addressing the issues outlined above. It also could reduce unmet need as it would encourage people to accept a care package by allowing them to retain some additional income above the minimum level.

**Figure 2.11: The effect of introducing a 65% taper on people in domiciliary care with care costs of £150 per week, by income**

![Graph showing the effect of a 65% taper on domiciliary care costs](image)

Source: Commission analysis

**Universal deferred payment scheme**

Since October 2001, local authorities have had the discretion to enter into deferred payment arrangements with care home residents. This scheme helps those who need to access the wealth tied up in their property in order to pay for their care, but cannot or do not wish to sell their homes.

Through this scheme, the individual is able to postpone paying the full cost of a care home placement. The local authority puts a legal charge (similar to a mortgage) on the care home resident’s property and in return pays their residential care fees in full. As for people in the means test, the resident is expected to contribute from their income if they can afford to. The local authority’s costs are recouped on the sale of the property, either during or after the care home resident’s lifetime.

Eligibility for the deferred payment scheme is limited to people who cannot afford to fund their care home placement out of their income and non-housing assets. Furthermore, the scheme is offered at the
discretion of local authorities, which can choose whether to offer a deferred payment on a case-by-case basis. As local authorities are not allowed to charge interest, the scheme is run at a loss (and is in effect a subsidy to care recipients) and there is an incentive not to offer or promote it. As a result, deferred payments are not widely used.

We believe that the deferred payment scheme should be made more widely available to those who could benefit. To make this possible it should be cost neutral to the state – with interest accruing on the payments owed (although it may require an initial cash injection). With this in place, local authorities should have a duty to offer deferred payments to all those eligible. Eligibility should include those who cannot meet the pre-cap contribution, as well as those post-cap who cannot afford to pay for their contribution towards their general living costs without using their housing assets.

4. The role of universal disability benefits

Under the current system, people with care and support needs receive disability benefits to support them in taking whatever action they believe would best help them manage their needs and maintain their quality of life. People can receive these disability benefits without receiving support from the social care system.

There are many different benefits for people with care and support needs, but two are particularly critical:

- Attendance Allowance (AA), which is a benefit for older people; and
- Disability Living Allowance (DLA) – which is a working-age benefit but which is also paid to people over state pension age who started claiming it when they were younger. The Government has already announced reform of DLA and the introduction of the Personal Independence Payment (PIP). Eligibility for PIP is based on a face-to-face assessment. Given these changes, the Commission’s suggested reforms as outlined in this section focus on AA only.

The rationale for retaining universal disability benefits in the new system

Many of the responses to our Call for Evidence called for universal disability benefits to remain unchanged. Some called for change, with greater integration with social care being by far the most popular, though abolition, means testing and increasing rates were all mentioned in this context.

The Commission has considered carefully the role of universal disability benefits and believes that there are strong arguments for retaining universal disability benefits in the new system.
We understand that people appreciate cash benefits as they provide choice and control, and support people to live independent lives. People are free to spend their benefits in whatever way they choose, so they are able to decide what would make the greatest difference to their quality of life. Benefits might be spent on care or on a range of other things, but this choice empowers individuals in a way that more interventionist social care cannot.

A universal payment recognises the additional costs of having a care and support need, even if that need is not sufficient to generate eligibility for social care. Providing support as needs arise can change spending patterns and behaviours and prevent needs escalating.

Although some have suggested that means testing or abolishing AA would release savings to fund reform to social care, the Commission believes that the requirements for greater funding for social care and the funding for AA ought each to be considered on its own merits. Decisions about spending priorities need to be made in the broader context of government decisions about raising and spending money, rather than looking solely within the wider care and support system to fund changes to social care.

Finally, for people with lower-level needs, we believe it would be disproportionate to put them through a complex local authority assessment to determine exactly what care they require. Universal benefits use a much simpler assessment process, which is less of a burden on the individual and is less costly for government.

On balance, we believe the arguments above represent a compelling case for retaining universal benefits. We do not believe that these benefits should be means-tested.

**Clarifying the role of universal disability benefits**

Although we see a strong argument for retaining universal disability benefits, we think that their role is unclear in the current system. The current system does not make explicit the purpose of universal disability benefits, or their role in relation to the social care system. This is exacerbated by inconsistent treatment of benefits by local authorities when determining charges in the means-tested social care system and, in the case of AA, by an uninformative name.
What do people use AA for?
Little research has been done on the uses of AA, but what does exist shows that it has a variety of roles. Recent qualitative research carried out by the Department for Work and Pensions\(^\text{20}\) found that people use AA for a range of things, such as to pay for housework, laundry and gardening, while more dated academic research\(^\text{21}\) found that people saw AA as a component of their general income, rather than a direct contribution towards the cost of care.

Recent research into the Winter Fuel Allowance,\(^\text{22}\) carried out by the Institute for Fiscal Studies, found that the name of the benefit had a significant behavioural effect. People were much more likely to spend the extra money they received on fuel if it was labelled ‘Winter Fuel Allowance’ than if it came as part of general pension income. If we want people to use universal benefits to help them with their social care needs, and if we want individuals to have more clarity about the wider care and support system, then disability benefits should have appropriate names. ‘Attendance Allowance’ is not such a name. **The Commission therefore recommends that universal benefits in the new system be given a more meaningful name than Attendance Allowance.**

The interaction of benefits with the social care system
In Section 3.1 of this report we suggest that the Government considers greater alignment between social care and assessments for disability benefits. Below we consider how benefits should be treated within our funding model.

Benefits and residential care
AA is not currently paid to people in state-funded residential care, but care home residents who are self-funding retain their AA. This seems a sensible approach: the care home package meets most of the costs for which AA is intended (such as cleaning, cooking and formal care). If it is being funded by the state then AA should be withdrawn, otherwise the state would be paying for the same cost twice; if it is funded by the individual then they should retain their AA as a contribution towards the care home package.

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\(^{21}\) *The Attendance Allowance and the Cost of Caring: The interaction of culture and economics in England*, Horton C and Berthoud R, Policy Studies Institute, 1990

\(^{22}\) *Cash by any other name? Evidence on labelling from the UK Winter Fuel Payment*, presentation delivered at Institute for Fiscal Studies briefing, 2011.
Under the new social care funding system proposed by the Commission, more people would receive state-funded residential care. The same rationale applies to these people as to those in the means-tested system: **if the state is paying for a care home package then it is already covering most of the costs for which AA is intended, so AA should be withdrawn.** The potential savings associated with this recommendation are estimated in Section 2.2 on costs and impacts.

**Benefits and domiciliary care**
People in state-funded domiciliary care currently continue to receive AA, but may be required to put some of it towards the cost of their care package. Local authorities treat AA as general income, but make an assessment of how much income a person should be left with – in addition to the £170 per week minimum – to cover the care-related costs for which AA is intended. There is variation in how this assessment is made: some local authorities leave everyone with the same amount to cover these costs except in certain circumstances, while others assess how much each person needs on a case-by-case basis. Government may wish to consider standardising the way in which AA is taken into account in the social care domiciliary care means test to provide greater clarity and consistency.

In the new system there would be a number of people receiving state-funded domiciliary care who are not in the means-tested system. They would therefore not be subject to an income assessment, and it would not seem appropriate to scrutinise their finances to determine how much of their benefits they need for disability-related costs. Benefits should be treated as income for this group, as they are for those in the means test. **People who have reached the cap would not be required to contribute towards their care package from their income, so they would not be required to use their benefits for this purpose either.**

**Integrating assessments**
The assessment process for AA is largely self-reported, and is based around what activities the person can or cannot carry out. In the discussion of assessment scales earlier in this section, we suggested that in future the Government might look at whether this assessment process can be better aligned with social care.

**Next steps**
In this section, we have explained how our proposed funding model could work in practice. It will be for the Government to take forward the detailed implementation of the funding system.
The Commission is aware of a number of specific issues which would need to be worked through by the Government, including exportability (e.g. the treatment of those moving within the European Union) and information management. The Government will also need to consider transitional arrangements (which we discuss in more detail in Part 4 of this report).

In doing so, we think the Government should seek to draw on the expertise of key delivery partners such as local authorities and stakeholder organisations. The devolved administrations would also need to be consulted on matters in which they had an interest.
2.2 Costs and impacts

Cost of our core recommendations

We estimate that the net cost of our core recommendations in England in 2010/11 would be from £1.3 billion for a cap of £50,000, to £2.2 billion for a cap of £25,000 cost. The cost of a cap of £35,000 would be around £1.7 billion in 2010/11, or 0.14% of gross domestic product (GDP); £1.3 billion of this is the cost of putting a cap on care costs for older people at £35,000, net of benefits savings.

The impact of our proposals

• Under our core recommendations for older people, a large proportion of people benefit. Anyone eligible for state support under the current system would continue to benefit under our system. With a cap on care costs in place, everyone would know that there was a limit on the amount that they will have to pay, and therefore the amount of their assets that they stand to lose. This reduces fear and anxiety and frees people to spend earlier and on preventative interventions.

• The majority of younger adults currently receive their care for free and will be unaffected by the introduction of a cap. However, the small minority who pay for their care privately will benefit from a cap on the costs that they face.

• Those with assessed assets between £23,250 and £100,000 would benefit from increasing the upper threshold in residential care, which defines eligibility for access to means-tested support.

• Carers should benefit from extra resources going into services.

• The social care system will remain highly progressive after our core reforms are adopted, with over 75% of public expenditure on older people going to the bottom three income quintiles. Those in the highest income quintiles receive almost no support from the current system and therefore, unsurprisingly, see the largest absolute increase in public expenditure. As a proportion of income, the benefits of reform are distributed evenly across the income quintiles. If the additional money to pay for our reforms were raised through direct taxation, those in the higher income quintiles would pay greater proportions of their income towards the additional costs.
Introduction

This section sets out the costs of our reforms (both now and over the longer term), how they might be paid for, their impacts upon different groups and the wider consequences of our proposals.

The analysis presented here focuses primarily on our core recommendations: the introduction of a cap on care costs of between £25,000 and £50,000 (we have modelled using the figure of £35,000) and the raising of the upper asset threshold in the residential care means test from £23,250 to £100,000. We are also suggesting that the Government consider some further reforms, which are discussed at the end of this section.

Headline costs of our core recommendations

The figures below show estimated public costs of the core recommendations compared with the costs of the current adult social care system. The sources of these estimates are described later in this section.

The core recommendations consist of:

• **a lifetime cap on care costs**, after which individuals in residential care would make a contribution to general living costs. We believe that the cap should be between £25,000 and £50,000 (we have used a cap of £35,000 for our analysis below). We have looked at a contribution to living costs ranging from £7,000 to £10,000 p.a., and have used £10,000 p.a. for our analysis; and

• **raising the upper assets threshold of the means test for people in residential care** to £100,000 from £23,250.

All costs are shown in 2010/11 prices, and assume that the reforms are fully implemented in each of the years. The costs are shown for 2010/11 in order to make a comparison with current levels of spend. In practice, the core recommendations are unlikely to be implemented before 2014/15 and, depending on how they are implemented, the costs in the first few years might be lower than those quoted here.
Figure 2.12: Public expenditure costs of the current system, and the additional costs of the Commission’s core recommendations as a percentage of GDP\(^1\)

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2015/16</th>
<th>2020/21</th>
<th>2025/26</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current system</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult social care</td>
<td>1.16%</td>
<td>1.19%</td>
<td>1.28%</td>
<td>1.39%</td>
</tr>
<tr>
<td>Disability Living Allowance(^2) and Attendance Allowance</td>
<td>0.93%</td>
<td>0.94%</td>
<td>0.92%</td>
<td>0.91%</td>
</tr>
<tr>
<td><strong>Additional costs of reform</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costs of recommendations</td>
<td>0.14%</td>
<td>0.16%</td>
<td>0.19%</td>
<td>0.22%</td>
</tr>
</tbody>
</table>

Figure 2.13: Public expenditure costs of the current system, and the additional costs of the Commission’s core recommendations (£ billion, 2010/11 prices)\(^3\)

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2015/16</th>
<th>2020/21</th>
<th>2025/26</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current system</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult social care</td>
<td>14.5</td>
<td>16.0</td>
<td>19.0</td>
<td>22.8</td>
</tr>
<tr>
<td>Disability Living Allowance and Attendance Allowance</td>
<td>11.7</td>
<td>12.6</td>
<td>13.7</td>
<td>14.9</td>
</tr>
<tr>
<td><strong>Additional costs of reform</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costs of recommendations</td>
<td>1.7</td>
<td>2.2</td>
<td>2.8</td>
<td>3.6</td>
</tr>
</tbody>
</table>

---

1. The costs are England only costs and are expressed as a proportion of England only GDP because any additional resources allocated in England would result in additional sums being allocated to the devolved administrations.

2. For those over age 18, care component only.

3. England only costs. As adult social care is a devolved matter any additional spending in England would result in additional sums (of around 19%) being allocated to the devolved administrations.
The following figures break down these costs to show the parts of the social care system to which they are attributable.

**Figure 2.14: Public expenditure costs of the current system (£ billion, 2010/11 prices)**

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2015/16</th>
<th>2020/21</th>
<th>2025/26</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older people</td>
<td>6.6</td>
<td>7.4</td>
<td>8.8</td>
<td>10.8</td>
</tr>
<tr>
<td>Younger adults</td>
<td>5.9</td>
<td>6.3</td>
<td>7.4</td>
<td>8.6</td>
</tr>
<tr>
<td><strong>Assessment and care management</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older people</td>
<td>1.1</td>
<td>1.3</td>
<td>1.6</td>
<td>2.0</td>
</tr>
<tr>
<td>Younger adults</td>
<td>0.9</td>
<td>1.0</td>
<td>1.2</td>
<td>1.4</td>
</tr>
<tr>
<td><strong>NET SOCIAL CARE</strong></td>
<td><strong>14.5</strong></td>
<td><strong>16.0</strong></td>
<td><strong>19.0</strong></td>
<td><strong>22.8</strong></td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older people</td>
<td>6.6</td>
<td>7.4</td>
<td>8.3</td>
<td>9.3</td>
</tr>
<tr>
<td>Younger adults</td>
<td>5.1</td>
<td>5.2</td>
<td>5.4</td>
<td>5.6</td>
</tr>
<tr>
<td><strong>NET TOTAL</strong></td>
<td><strong>26.2</strong></td>
<td><strong>28.6</strong></td>
<td><strong>32.7</strong></td>
<td><strong>37.7</strong></td>
</tr>
</tbody>
</table>

---

4 Disability Living Allowance (care component) for older people and younger adults; Attendance Allowance for older people.
## Figure 2.15: Public expenditure costs of core recommendations: additional costs (£ billion, 2010/11 prices)

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2015/16</th>
<th>2020/21</th>
<th>2025/26</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capping costs at £35,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older people</td>
<td>1.3</td>
<td>1.7</td>
<td>2.2</td>
<td>2.9</td>
</tr>
<tr>
<td>Younger adults</td>
<td>0.3</td>
<td>0.4</td>
<td>0.4</td>
<td>0.5</td>
</tr>
<tr>
<td>Raising upper threshold to £100,000 (with a cap in place)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older people</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Younger adults</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td><strong>Assessment and care management</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older people</td>
<td>0.2</td>
<td>0.2</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>Younger adults*</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>NET SOCIAL CARE</strong></td>
<td>1.9</td>
<td>2.4</td>
<td>3.0</td>
<td>3.8</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older people</td>
<td>-0.2</td>
<td>-0.2</td>
<td>-0.2</td>
<td>-0.3</td>
</tr>
<tr>
<td>Younger adults</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td><strong>NET TOTAL</strong></td>
<td>1.7</td>
<td>2.2</td>
<td>2.8</td>
<td>3.6</td>
</tr>
</tbody>
</table>

* costs less than £0.05bn

## Modelling assumptions

### Details of the models used

Below we provide a short summary of the modelling and central assumptions used in calculating these costs. Four models have been used to produce estimates of costs and impacts. In the annex to this report we provide a full explanation of the different models that we used during the course of our work.
<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
<th>Main uses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal Social Services Research Unit (PSSRU) microsimulation model</strong></td>
<td>This model covers older people only. It is a dynamic microsimulation model that simulates the incomes, wealth, disability, health status and use of care services for individuals on an annual basis, to 2025/26. Its comparative strength over the aggregate model for older people, described below, is its ability to model people’s paths through the care system and to produce analyses of the effects of alternative funding systems on different groups, e.g. by income or disability status.</td>
<td>• Overall cost of proposals</td>
</tr>
</tbody>
</table>
| **PSSRU aggregate projections model for older people** | This is a macrosimulation model that projects the future numbers of older people with disabilities, the likely level of demand for care services and disability benefits, and the costs associated with meeting this demand. Its comparative strength over the microsimulation model is in producing cost projections over the longer term and conducting sensitivity analyses. | • Used in conjunction with output from CARESIM (described below) to project future costs of the current system and different elements of our proposals  
• Sensitivity analysis on trends in mortality, disability and unit care costs                                                                                                                                                                                                                                                                         |
Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
<th>Main uses</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARESIM</td>
<td>This is a microsimulation model of older people that models the evolution of gross incomes and assets of a sample of people aged 65+, calculates their income tax liability and entitlements to means-tested benefits and then assesses what they would be required to pay towards different kinds of care, should they need it, under different funding options.</td>
<td>• Used in conjunction with aggregate model (described above) to project future costs  • Analysis of the impact of proposals on different groups</td>
</tr>
<tr>
<td>The PSSRU aggregate projections model for younger adults</td>
<td>This is a macrosimulation model that projects the future numbers of younger adults with disabilities, the likely level of demand for care services and disability benefits, and the costs associated with meeting this demand.</td>
<td>• All costs and projections for younger adults</td>
</tr>
</tbody>
</table>

**Key assumptions used in modelling the cap**

Unless otherwise stated, estimates assume a cap of £35,000 in 2010/11, rising in line with the earnings over time (as a proxy for our proposal that it would rise in line with the basic state pension).

The cap relates to care costs only and excludes spending on general living costs. After the cap is reached, people in residential care would be expected to make a fixed contribution towards general living costs of £10,000 p.a., compared with the average cost of residential care of around £28,500 p.a. Those who cannot afford this from their income and assets would receive means-tested support under the same rules as the residential care means test. This means-tested support is also included in the cost estimates.

For younger people, the estimates of the cost of free care are used as proxies for the costs of a cap, given the limited information of care pathways and individual contributions towards care charges among younger adults. This estimate is, in effect, the cost of a cap set at zero and will be an over-estimate of the costs of our proposals for younger adults.
It is assumed that, under a free care model, younger people would still make a contribution towards general living costs of £10,000 p.a., if they can afford to do so.

**Discussion of cost estimates**

**The cost of the current system**

Estimates of the future cost of the current system are from the PSSRU aggregate projections models for older people and younger adults. These are the most suitable models for projecting long-term costs. The PSSRU aggregate and CARESIM models assume that real care costs will be held constant until 2015 (in line with assumed earnings growth). We have taken the more cautious approach of assuming that care costs rise in line with GDP growth over the entire period.

**The cost of introducing a cap**

*Older people*

**Costs in the year of implementation**

Using results from the PSSRU microsimulation model, we estimate that a cap on care costs at £35,000 – subject to an individual contribution towards general living costs of £10,000 p.a. – would have cost an extra £1.2 billion if it had been in place in 2010/11.

The cost of this reform has also been estimated using a combination of the CARESIM model and the PSSRU aggregate model for older people. The estimate is £1.3 billion in 2010/11. The estimate is on the basis of assumptions about care pathways.

By looking at intermediate results from the PSSRU microsimulation model, we can understand in simple terms how its estimate arises.

Total public and private spend on social care for older people is estimated at around £9 billion p.a. for people who have sufficient needs to be eligible for local authority support. Costs are set at the price of the care package that the local authority would provide them with, and exclude general living costs.

Figure 2.16, derived from the model, shows lifetime care costs for those entering care and how much the state and individuals would contribute in the absence of means-tested support. It suggests that around a third of this spend – £3 billion p.a. – is spent on people who have accumulated more than £35,000 worth of care needs. Under the current means-tested system, individuals pay around 40% of all social care costs from their own resources, so we would expect around £1.2 billion to be spent each year by individuals who have accumulated more than £35,000 of care costs. It is this cost that the capped risk scheme would cover.
We can arrive at a similar figure using data that are not from the microsimulation model, validating and giving greater confidence in the result.

Once the cap is in place, the state would pay all care costs for those who had accumulated more than £35,000 of eligible care costs over their lifetime. Most of these people would be in residential care; using length-of-stay data submitted to the Commission we estimate that, at any one time, around 54% of care home residents will have accumulated more than £35,000 of care spend. Assuming that there are 110,000 self-funders with care needs which meet local authority eligibility thresholds for residential care, the total annual cost of providing care for this group would be £1.1 billion p.a.

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5 This chart looks only at people who enter care, ignoring the quarter of 65 year-olds who can expect to need little or no formal care. The effect of the means test is not shown — in practice some people would receive additional help in making their contribution. Costs are adjusted for care cost inflation and presented in 2009/10 care prices, to reflect the effect of a cap that rises in line with care costs.

6 Assuming that on average people spend £5,000 on domiciliary care before entering residential care people would need to accumulate spend of £50,000 in residential care before they hit the cap. With annual care costs in residential care of £18,500, this represents a stay of 1.6 years. Length of stay data provided by BUPA in response to the Commission’s call for evidence.

7 Laing & Buisson estimate of self-funders, adjusted to cover only those who meet local authority eligibility thresholds.
There will also be some self-funders in domiciliary care who have accumulated more than £35,000 in care costs. Around £1 billion p.a. is spent by individuals on domiciliary care (including charges paid by those receiving means-tested support). If 20% of this spending relates to people who already spent £35,000 on care, the cost to the state of introducing a cap would be an additional £0.2 billion. The total cost for those in residential care would therefore be estimated at £1.3 billion.

Changing the level of the cap or the contribution that people in state-funded residential care are expected to make towards their general living costs will change the cost of the reforms. Costs will increase if the cap is lowered or the individual contribution towards general living costs reduced; costs will decrease if the cap is raised or the contribution towards living costs increased.

Figures 2.17 and 2.18 show estimates of the additional public expenditure in 2010/11 for different levels of the cap, produced by the two different models. The cost for a cap of zero is the cost of free care, which both models estimate as £3.8 billion in 2010/11.

**Figure 2.17: Additional public expenditure on care for older people in 2010/11 under a reformed system, by level of the cap**

![Graph showing additional public expenditure on care for older people in 2010/11 under a reformed system, by level of the cap.](image-url)

Sources: ESHCRU/PSSRU microsimulation model; PSSRU aggregate model/CARESIM

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8 Estimates assume that individuals in residential care contribute £10,000 p.a. towards their general living costs
Figure 2.18: Additional public expenditure on care for older people in 2010/11 under a reformed system, by level of contribution to general living costs

![Graph showing additional public expenditure on care for older people in 2010/11 under a reformed system.](image)

Sources: ESHCRU/PSSRU microsimulation model; PSSRU aggregate model/CARESIM

Figure 2.19 below shows combined estimates from both models for public expenditure for different levels of the cap and contributions to general living costs.

Figure 2.19: Additional state expenditure on care for older people in 2010/11, by level of the cap and contribution to general living costs (£ billion)

<table>
<thead>
<tr>
<th>Living costs</th>
<th>£25,000</th>
<th>£35,000</th>
<th>£50,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>£7,000</td>
<td>2.2</td>
<td>1.7</td>
<td>1.1</td>
</tr>
<tr>
<td>£10,000</td>
<td>1.7</td>
<td>1.3</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Sources: PSSRU microsimulation model and PSSRU aggregate model for older people (average of results from the two models), and Commission analysis.

Projections of future costs

The **PSSRU aggregate model for older people, in combination with CARESIM**, is the most appropriate to use for forecasting future costs of the current system, while the **PSSRU microsimulation model** is better for comparing different funding models, and allows us to look at the effects of changes on different groups. In order to estimate the difference in cost between the current system and the reformed system, and how this changes over time, we have therefore used a combination of results from the two models.

9 Estimates assume a cap of £35,000
The approach that we have used is to take the projections of the cost of the current system in each year from the aggregate projections model, and to multiply these by the cost of the cap as a proportion of the current system costs. The proportion in each year is the average of the proportions from the microsimulation model and from the CARESIM/aggregate model. The calculation is shown in Figure 2.20.

**Figure 2.20: Cost projections using the PSSRU microsimulation and aggregate models**

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost of current system (£billion) – aggregate model</th>
<th>Cost of cap as proportion of current system costs</th>
<th>Additional cost of a £35,000 cap (£billion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>6.6</td>
<td>18.1% 20.3% 19.2%</td>
<td>1.3</td>
</tr>
<tr>
<td>2015/16</td>
<td>7.4</td>
<td>21.8% 23.1% 22.4%</td>
<td>1.7</td>
</tr>
<tr>
<td>2020/21</td>
<td>8.8</td>
<td>25.3% 24.6% 25.0%</td>
<td>2.2</td>
</tr>
<tr>
<td>2025/26</td>
<td>10.8</td>
<td>26.6% 26.6% 26.6%</td>
<td>2.9</td>
</tr>
</tbody>
</table>

The cost of the cap rises in proportion to the cost of the current system over time for two reasons. Firstly, the rate of home ownership amongst older people is forecast to rise over the next 15 years which increases the proportion of people who will be ineligible for means-tested support and who would therefore derive greater benefit from the cap. Furthermore, a smaller proportion of people will be eligible for means-tested support because asset thresholds are assumed to rise in line with general inflation whilst wealth and incomes rise in line with GDP growth.

Secondly, the modelling assumes that, over time, age-specific prevalence of disability remains constant. This means that as life expectancy increases, the expectancy of life with disability also increases. The proportion of total costs covered by the cap therefore rises over time. However, in practice the government could, if it wished, raise the cap to offset this effect.

**Younger adults**

For younger adults, the estimates of the cost of a cap are from the PSSRU aggregate projections model. Our recommendation is that the cap for younger adults is set at a level to reflect their ability to accumulate assets up to the onset of their care need. The cap for people turning 18 with a disability would be set at zero and it would rise in tiered steps up to the

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10 Costs relate to care only (i.e. exclude assessments and care management) and are in 2010/11 prices.
full cap of £35,000 at age 65. The lack of data on the care journeys of younger adults makes modelling this difficult, so we have modelled the costs of a cap set at zero for everyone under 65 – that is, free care for all younger adults – in order to provide us with an upper limit on costs.

The main beneficiaries of free care would be those adults who are currently self-funding because they fall outside the safety net; the size of this group is unknown, but thought to be small as the majority of younger adults receive means-tested support. Some younger adults receiving means-tested support would also benefit from no longer having to pay charges. However, charges represent only 5% of gross social care spend on younger adults and some of this charge income would continue as the contribution to general living costs for those in residential care.

As a result, the cost of free care for younger adults is relatively low. It is estimated as between £0.17 billion and £0.39 billion in 2010/11; our central estimate is £0.28 billion.

Assessment and care management

Introducing a cap on care costs will require people who are currently self-funding to be assessed by local authorities, in order to determine the rate at which they progress towards the cap. Under the current system, many of these people will not have assessments, as they are aware that they are unlikely to be eligible for state support. We would therefore expect the proposed reforms to lead to an increase in assessment costs.

When an individual first enters the social care system they are given a full assessment, the cost of which is estimated at around £400. The local authority will subsequently reassess them at least annually to see if their needs have changed. Reassessments are, in general, simpler than initial assessments, and the average cost is estimated at £200. The additional numbers of assessments of each type are estimated below, for older people and younger adults.

There may also be increased care management costs from the new system, if more people require the local authority to manage the provision of their domiciliary care.

The estimated additional assessment and care management costs resulting from the reforms are summarised in Figure 2.21. The derivation of these costs is discussed in the following parts.
Figure 2.21: Summary of additional assessment and care management costs resulting from the proposed reforms

<table>
<thead>
<tr>
<th></th>
<th>Older people</th>
<th>Younger adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>First assessments</td>
<td>£0.08 billion</td>
<td>£0.02 billion</td>
</tr>
<tr>
<td>Reviews</td>
<td>£0.09 billion</td>
<td></td>
</tr>
<tr>
<td>Care management</td>
<td>£0.02 billion</td>
<td>£0.00 billion</td>
</tr>
<tr>
<td><strong>Total for older people</strong></td>
<td>£0.19 billion</td>
<td><strong>Total for younger adults</strong></td>
</tr>
<tr>
<td><strong>Total additional costs</strong></td>
<td></td>
<td>£0.21 billion</td>
</tr>
</tbody>
</table>

**Older people**

First assessments
We estimate that, with a cap in place, the number of first assessments for older people will increase by 40%. This is our estimate of the ratio of self-funders entering the care system per year (who, with a cap in place, would need an assessment to start their meter) to the number of those people receiving local authority support currently entering the care system each year.

There were 487,000 first assessments of older people in 2009/10,\(^\text{11}\) with an estimated cost of around £0.2 billion. A 40% increase on this is an additional 190,000 assessments, costing an additional £0.08 billion. There is some uncertainty around this estimate, and it may be on the high side, as the additional number of assessments is higher than the number of people entering care each year. The extra numbers may relate to people who are assessed, but turn out not to be eligible for local authority support.

Reassessments/reviews
We estimate that, with a cap in place, the number of reviews for older people will increase by 50%. This is our estimate of the ratio of the current number of (needs-eligible) self-funders in the system to the current number of people who receive means-tested support from local authorities.

There were 884,000 reviews in 2009/10, with an estimated cost of around £0.2 billion. An additional 50% (440,000) would cost an extra £0.1 billion. Again, there is some uncertainty around this estimate, as the number

\(^{11}\) Referrals and packages of care 2009/10 (RAP), NHS Information Centre.
of additional reviews exceeds the number of additional people that we think would be receiving state support.

**Care management**

It is not clear that, with a cap in place, there needs to be any expansion in care management. Those who are paying for all their own care under the current system will continue to do so up to the cap of £35,000. After reaching the cap, they could continue to manage their own care and make payments to their provider before being reimbursed by the local authority to the value of their assessed care package. However, it is possible that some of those self-funders receiving care in the community or at home will want to have their care managed by the local authority once they reach the cap. For example, assuming that there are 150,000 self-funders in domiciliary care, and that 20% of these have exceeded the cap and that half of these want local authority care management, we get an additional number requiring care management of 15,000. Assuming that care management costs around £1,000 per person p.a., the additional cost is £0.02 billion.

**Younger adults**

**Assessment and reassessment**

The additional cost of assessment for younger adults is estimated from the PSSRU aggregate modelling of the costs of free care. As discussed above, most younger adults are already eligible for support under the means-tested system. This approach is likely to lead to an overestimate of the costs for this group, so the result should be seen as an upper bound. The costs of assessments and reassessments are £0.01 billion–£0.03 billion. We have assumed £0.02 billion as a central scenario.

**Care management**

We assume that, under a capped cost model, the additional cost of care management would be zero: when self-funders, who are predominantly in residential care, hit the cap then they will continue to manage their care themselves.

**Raising the upper asset threshold in the residential care means test**

**Older people**

Without a cap on costs, raising the upper asset threshold in the residential care means test potentially benefits those who, at some stage in their care journey, have assets which fall below £100,000 in value. Because there is no limit on the costs that people face, anyone who starts their care journey with assets greater than £23,250 could benefit. The cost of raising the asset threshold to £100,000 in the absence of a cap is estimated to be between £0.10 billion (the PSSRU microsimulation model estimate) and £0.27 billion (the PSSRU aggregate projections/CARESIM model estimate) in 2010/11.
However, with a cap of £35,000, no one with assets of greater than £135,000 at the start of their care journey would spend down to £100,000 (as a result of spending on their metered care package). The potential beneficiaries are therefore those who start their care journey with assets of between £23,250 and £135,000. With a cap in place, the cost of raising the upper asset threshold to £100,000 is estimated as between £0.05 billion (the PSSRU microsimulation model) and £0.12 billion (from the PSSRU aggregate/CARESIM model). Our central estimate is £0.10 billion.

The models assume that the £100,000 threshold rises over time in line with prices.

**Younger adults**

In estimating the cost of the cap for younger people, we have used the cost of providing all care free of charge as an upper bound, as discussed previously. Any additional care costs arising from raising the asset threshold to £100,000 for younger adults are therefore included in this cost estimate.

As the means test also applies to general living costs for those in residential care, there may be some people who receive additional support from the extended means test. However, the cost of this to the state is likely to be very small.

**Disability benefits**

**Older people**

Under our recommendations, those self-funders in residential care who reach the cap would lose their entitlement to AA and DLA, in the same way that people receiving means-tested residential support do currently. This produces a saving on the current system. Estimates of the savings have been based on results from the aggregate model which estimates savings of between £0.16 billion and £0.26 billion. We have taken the average of these, £0.21 billion, as our central estimate.

**Younger adults**

There will also be some analogous savings to DLA for younger adults. These are difficult to estimate because of the lack of information on self-funders in residential care and because DLA is to be reformed. People who are currently self funders but who, under our proposals, would be receiving local authority care would lose their entitlement to DLA. But because of the small number of self-funders among younger adults, the savings will be small (we have assumed zero as our central estimate).
**Sensitivity of costs to key assumptions**

Many assumptions underpin the cost estimates and projections set out above and there is uncertainty about these. There is therefore a range of uncertainty around the estimates. In the discussion above we have given indications of where specific assumptions would affect the 2010/11 cost estimates of the individual elements of our recommendations.

There are other, broader, uncertainties that affect the costs of both the current system and the new system. These are discussed below. In order to give a sense of the importance of each of the key uncertainties, we have quantified how changes in the assumptions affect the projected costs of the current system over the next 15 years. This gives an indication of the sensitivity of the future additional costs of our reforms to changes in the assumptions.

**Figure 2.22: Key sensitivities and their effects on current system costs, as a percentage change on 2010 base case in 2025**

<table>
<thead>
<tr>
<th><strong>Older adults</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unit costs of care</strong></td>
</tr>
<tr>
<td>Grow 1 percentage point faster than base case (3% per year)</td>
</tr>
<tr>
<td>Grow 1 percentage point slower (1% per year)</td>
</tr>
<tr>
<td><strong>Prevalence of disability</strong></td>
</tr>
<tr>
<td>Pessimistic ‘continuing trends’ scenario as used by Jagger et al</td>
</tr>
<tr>
<td>Decrease of 1% per year in age/gender-specific disability prevalence rates</td>
</tr>
</tbody>
</table>

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12 Current obesity trends (of 1–2% increase p.a.) continue, resulting in higher prevalence of arthritis, stroke, coronary heart disease and vascular dementia but also their associated disability. Ethnic minorities enter the older population in significant numbers and add to the prevalence of stroke and coronary heart disease. Most treatments continue to focus on reducing the mortality from diseases rather than reducing the disabling effects. See for example *The impact of changing patterns of disease on old age disability: a macro-simulation modelling approach*, Jagger C, Matthews R, Lindesay J, Robinson T, Croft P, Brayne C and MRC CFAS. Submitted to the *Lancet*. 
**Younger adults**

<table>
<thead>
<tr>
<th>Unit costs of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grow 1 percentage point faster than base case (3% per year)</td>
</tr>
<tr>
<td>Grow 1 percentage point slower (1% per year)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prevalence of disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper prevalence rate for learning disability as used by Emerson and Hatton (2008)</td>
</tr>
<tr>
<td>Lower prevalence rate for learning disability as used by Emerson and Hatton (2008)</td>
</tr>
<tr>
<td>Increase of 1% per year in the prevalence of physical disability</td>
</tr>
<tr>
<td>Decrease of 1% per year in the prevalence of physical disability</td>
</tr>
</tbody>
</table>

**Unit costs**

The central assumption is that unit costs rise in line with expected GDP growth, i.e. broadly in line with earnings. This has been the case in the past, but may not hold true in the future:

- Unit costs of care could exceed the growth rate of the economy. This could occur if growth in wage rates in the care sector exceeded that on average across the economy, for example due to a lack of supply of labour in the sector, or if the reforms stimulated demand for formal care services faster than supply could respond, such that providers could increase real prices without losing custom.

- Unit costs of care could change as a result of changes in people’s expectations (for example about quality of care), government policies or regulatory changes.

- Unit costs of care could fall short of the growth rate of the economy. This could occur if, for example, wages of care staff rose more slowly than average earnings or technological advances meant that people’s ability to remain independent was enhanced with lower cost interventions. Examples of this are already in evidence, such as telecare, the unit cost of which may be lower than having a formal carer regularly visit a person’s home.

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We have modelled unit costs rising by 1 percentage point more and 1 percentage point less than the base case (unit costs rise in line with GDP over the next 15 years – 1.5% p.a. up to 2015, then 2% p.a.).

**Prevalence of disability**

For older people, the central assumption used in the modelling which forms the basis of our cost estimates is that the prevalence of disability remains constant over time by age and gender, i.e. the same proportion of people of a particular age and gender will be disabled in every future year.

Data from the English Longitudinal Survey of Ageing support this assumption of unchanging age-specific prevalence.\(^{14}\) However, this is an area in which there is much debate and there is no clear consensus about the recent trend in England. In the past, the assumption of constant age-specific prevalence of disability – and its corollary, that life expectancy with a disability will increase as life expectancy increases – has been viewed as pessimistic, i.e. possibly overestimating future prevalence. Conversely, recent work undertaken for the Commission by Professor Carol Jagger\(^ {15}\) suggests that this assumption may be an underestimate of future prevalence. There is no clear international trend; different countries have different experiences.\(^ {16}\)

Assumptions about prevalence of disability will affect not only the overall numbers of people starting to need care but also the average duration of care need and the length of stay in residential care. Assuming that the propensity to use services for a given level of disability remains constant, if age-specific prevalence of disability remains constant and longevity increases, duration of stay in care increases. However, if age-specific prevalence increases then durations of stay in care would rise more quickly; while if age-specific prevalence decreases, durations would rise more slowly or even fall.

For older people, we have modelled unchanged prevalence as the central scenario and run sensitivity analysis with a more optimistic scenario, and a more pessimistic scenario based on Jagger’s work. For younger adults with a learning disability, we have modelled prevalence rates based on

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14 Analysis by the Institute for Fiscal Studies carried out for the Commission.


work by Emerson,17 which shows increasing prevalence over time. For younger adults with a physical disability, prevalence remains unchanged in the base case. We have modelled more optimistic and pessimistic scenarios for each group.

**Longevity**

Our central assumption for life expectancy is the principal projection of the Office for National Statistics (ONS). Sensitivity analysis using the ONS high and low life expectancy variant population projections finds that this would not have as large an effect on projected social care expenditure as unit cost or morbidity changes. It is not therefore a key sensitivity that we have illustrated.

**Supply of unpaid care**

Demand for social care will increase in the future, so if unpaid care is to continue to meet the same proportion of care needs then supply of unpaid care will also need to increase. Assuming that the propensity of a family member to provide unpaid care will not change, this means that more family members will need to be in a position to provide care in order for supply to keep pace with demand.

Projections of marital status/cohabitation from the Government Actuary’s Department suggest that in the future a greater proportion of older people, by age, will have a surviving spouse or partner. This change will result from fewer men dying significantly before their wives. This may mean an increase in the supply of care by spouses, subject to the ability of spouses in late old age themselves to provide care.

However, the supply of intense unpaid care also relies on adult children caring for their parents. In order to keep pace with demand, it is estimated that 60% more adult children will need to be in a position to care for their parent(s) by 2031.18 If supply of unpaid were to fall short of this, demand for formal care and care costs could increase.

Although the supply of unpaid care is an important determinant of future costs, there are many possible future scenarios and we have not felt it sensible to try to quantify the range of effects on costs.

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Behavioural responses

There are further uncertainties that arise from behavioural responses to our reforms. As behavioural responses are difficult to predict, and there is a lack of data from which to produce estimates, we have not attempted to quantify their effect. These responses could include the following:

Reduced ‘playing’ of the system

We have heard many reports of people ‘playing’ the current system – disposing of or hiding housing and other assets so that they qualify for state support in residential care. The current system provides a huge incentive to do this and if widespread the cost to the state could be significant. Even if only 5% of all those who should be self-funders played the system by disposing of assets, there would be at least 5,000 more supported residents. This would cost over £100 million per annum. Introducing a cap greatly reduces the incentive to ‘play’ the system in this way.

Increased preventative action on the part of individuals

Successful reform would lead to increased awareness of the system, increased preparation and, with the impact of the cap removing fear of future calls on income, increased spend earlier on in the care journey. Increased preventative and responsive action could lead to reduced entry into the social care system and a slower escalation of needs for those that do enter. This would lead to reduced future costs to the social care system as well as to the NHS more generally.

Non-take up of the cap offer among some higher income groups

Modelling has assumed that take-up of the cap offer is the same as take-up for means-tested support. In practice, take-up may be less than this, lowering the cost. Take-up of means-tested benefits targeted at low income groups, where there is an immediate financial gain available, is significantly below 100%. We might therefore expect take-up of the cap offer, where the financial gain for individuals will not be immediate, and considering that some groups may not wish to engage with the state, to be lower still.

Summary

Our central estimate of the net public expenditure cost of our proposals for a £35,000 cap and a £10,000 p.a. contribution to general living costs, together with an increased upper capital limit for the means test for residential care, is £1.7 billion p.a. in 2010/11. There are considerable uncertainties surrounding this estimate but in making it we have adopted

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19 The latest statistics from the Department for Work and Pensions show that take-up of Pension Credit was between 62% and 73% and take-up of Council Tax Benefit was between 63% and 70%.
cautious assumptions. There are several reasons why the costs could be significantly lower than our central estimates, which are as follows:

- The cost of the cap for younger adults could be lower than our estimate, which is, in effect, the cost of providing free care. Many working-age adults with disabilities will have developed their disabilities in their 50s, by which time they have accumulated significant assets and are therefore able to make a contribution to their care costs.

- Take-up of the capped offer, which we have assumed is the same as for means-tested support, could be lower because higher wealth groups are less likely to take state support.

- There is likely to be a reduction in ‘playing’ of the system, as the cap significantly reduces the incentive to dispose of or hide assets.

**Paying for the reforms**

Given the relatively low cost of our proposals, we believe that the Government is best placed to determine how to fund the reforms, looking across all areas of public spending.

The Commission believes that there are three possible ways for our recommendations to be paid for, which are that:

- the Government may decide that it wishes to raise additional revenue through general taxation – this is the way in which the current system is funded; or

- it may choose to reprioritise existing expenditure, because it places greater value on this than other spending; or

- it may decide to introduce a specific tax increase, and if it did so, it would make sense for this to be paid at least in part by those who are benefiting directly from the reforms. In particular, it would seem sensible for at least a part of the burden to fall on those over state pension age. But if the Government decides to raise additional revenue, we believe that it would be sensible to do so through an existing tax, rather than by creating a new tax.

In making its decision on how to pay for reform, we believe that the Government needs to consider the impact of any funding mechanisms on different income and generational groups.
Impacts on different groups

General approach to assessing impacts

There are two broad ways in which our core funding reforms will benefit people. Firstly, they will provide people with financial protection against high care costs, and as a result reduce the fear and anxiety that people feel. This benefit can be quantified by comparing it with the cost that people would pay for insurance, were they able to buy such a product.

Secondly, by reducing the lifetime costs of care that people face our reforms make it easier for people to buy the care they need, and so will reduce unmet need. The resulting improvements in quality of life from this reduction in unmet need are harder to quantify.

Reducing fear and anxiety: the benefits of social insurance

Under the impact of our core recommendations, no-one is worse off and a large proportion of people benefit. Around a quarter of 65-year-olds can expect to hit the cap and benefit directly from free care. This means that a far greater number of people will, in future, benefit from state support.

But these are not the only people to benefit. We can look at the cap as a population-wide social insurance with an excess of £35,000. Just as everyone who insure their house against burglary benefits from that insurance – not just those who suffer a burglary – everyone with significant savings benefits from having a cap on their lifetime care costs. With the cap in place, everyone knows that there is a limit on the amount that they will have to pay. This removes fear and anxiety, and frees people to spend earlier and on preventative interventions. The benefits of being covered by social insurance in this case are discussed further in Section 2.3 (assessing the funding models).

We have quantified the minimum benefit of social insurance for different groups by calculating an actuarially fair price for this insurance if it were applied to that group only. In practice the benefits to each group will be greater than this, because people are willing to pay for insurance substantially above its actuarially fair price. Insuring through risk-pooling, rather than self-insuring, leads to a positive income effect. In other words people can expect to have greater available resources under a social insurance model. The additional welfare gains from these benefits are not quantified here.

Reducing unmet need

Capping the care costs that people face over their lifetimes at £35,000 will reduce unmet need: it encourages people to start spending on care when they need it, by removing uncertainty about how much they may need in the future, and the fear that they may lose almost everything and become dependent on state support.
Ensuring that the social care system is adequately funded will also help local authorities to meet the needs of their populations, while providing people with better information and advice about what services are available will help people to get appropriate care and support.

However, we still lack direct measures of unmet need across England. Through our Call for Evidence, we received the results of some surveys carried out by stakeholder organisations, but no systematic evidence. Due to the difficulties in estimating these benefits, they have not been quantified here.

**Impact on people with disabilities and health conditions**

The current system provides support to people with disabilities through services and benefits – but social care support is only provided if people do not have the means to pay for their own care. Our core recommendations give greater support to this group by extending social care support to all people with disabilities, regardless of their wealth.

Those who have a disability throughout their life have lower employment rates and incomes than those without a disability. This means that they are less likely to be able to plan for any future care needs. The employment rates of disabled people are around 48%, compared with around 78% of non-disabled people.20 Both before and after housing costs, a higher proportion of individuals living in families with at least one disabled member live with a low income, compared with individuals living in families with no disabled members. Disabled adults are more likely to live in persistent poverty than non-disabled adults.21

Our proposals recognise this, and support disabled people by ensuring that those who develop extensive needs earlier on in life receive state-funded care quickly, without having to pay the full contribution that is required of those who develop a care need later in life.

We also believe that our proposals support people with all types of care need, be it continuous or episodic, and including physical and learning disabilities and those with mental health conditions. People with specific health conditions, who can also have high social care needs – such as those with dementia, Parkinson’s disease, and motor neurone disease – can face high lifetime care costs, so again will benefit from the cap.

**Impact on carers**

Improving the system for those with a care need will also offer carers greater support. Carers are a vital element of the care and support

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20 Office for Disability Issues. Figures are for 2010 from the Labour Force Survey.
21 Disability Equality Indicators, ODI Roadmap 2025.
system, with 5 million people currently caring in England (12% of people aged 16 or over). Yet they face worse health and employment outcomes than their counterparts without caring responsibilities. For example, the Organisation for Economic Co-operation and Development (OECD) 2011 study of long-term care finds that carers exhibit a prevalence of mental health problems across OECD countries which is 20% higher than among non-carers, particularly for those who provide more intensive care.

The OECD also finds that, in the UK, unpaid caring is associated with a higher probability of both stopping working and switching to part-time work, even after taking account of other socio-demographic factors such as age, marital status and education. Among carers of working age in England, 26% feel that their caring responsibilities have affected their ability to take up or stay in employment, while one in six carers has given up work or reduced their hours in order to provide care. It is therefore important that reforms carefully take into account the impact on carers and aim to support them as fully as possible.

By setting a limit on the maximum amount that people have to spend, our proposals encourage people to spend on their care, by freeing them of the fear that they will be exposed to very high and uncertain costs. Our proposals should therefore lessen the responsibilities that some carers currently face over the course of their lifetime. This may be particularly relevant to carers of people with a learning disability who can afford to pay for their own care. Three-quarters of the carers in this group have been caring for more than 20 years, compared with one in five carers overall.

With increased resources in the system, and with individuals facing reduced fear and anxiety (and so better able to spend money on their own care), the burden on carers would be reduced. Evidence suggests that better services for the cared-for bring real benefits to carers.

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24 While caring and employment may be negatively correlated, the direction of causation is not clear. Caring may negatively affect availability for work; alternatively, individuals with poor job prospects may be more likely to engage in caring activities.
27 The Learning Disabilities Observatory.
28 What are the most effective and cost-effective services for informal carers of older people?, Pickard L, Research in Practice for Adults, 2006.
Furthermore, our recommendations for a national eligibility and assessment framework, with portability of assessments, and for improved information and advice to both individuals and carers, should offer greater support and clarity to families.

**Impacts by income and wealth**

Differences in care and support needs echo the social gradient in health, where the lower a person’s socioeconomic position, the worse his or her health, as set out in the Marmot Review.\(^{29}\)

Lower income and lower wealth groups are more likely to need care and support in later life than higher income and higher wealth groups. Data from the English Longitudinal Study of Ageing find that average (mean) net liquid savings and property wealth of single people aged over 50 with no limitations of activities of daily living (ADL) is £188,000, compared with £120,000 for those with one or more limitation.

Meanwhile, people who develop a care and support need earlier in life will find their ability to build up income and wealth affected, and they are more likely to be on, and remain on, lower incomes.

Unless there are barriers to some people receiving services, we would therefore expect any care and support system to provide a large proportion of its services to those of lower income and wealth. This section uses quantitative results of modelling carried out for the Commission to estimate how public expenditure varies by income quintile, both in the current system and under our proposed reforms. It looks at the additional cost and benefits of the reforms for each quintile in order to identify which are net gainers and losers.

The analysis focuses on older people for two reasons. Firstly, our funding recommendations have the biggest impact on older people – because the vast majority of younger adult service users currently receive their care free or at minimal cost to them. Secondly, there is a lack of robust data at a national level on younger people with care needs and their incomes and assets.

**Asset protection for people of different levels of wealth**

Figure 2.23 shows how our core recommendations affect the proportion of a person’s assets that could be depleted if they had £150,000 of residential care costs to pay over their lifetime. Except for those with assets of £14,250 or lower (whose assets are already fully protected by the means test), our reforms offer everyone additional asset protection.

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Those who benefit most (as a proportion of their assets) are those whose assets would have been depleted by the greatest proportion under the current system. For a lifetime cost of £150,000, these people are at around the median wealth for homeowners. Under the current system, these people could lose almost 90% of their assets paying for care; under our proposals they cannot lose more than 20% with a cap of £35,000.

Raising the upper asset threshold of the means test to £100,000 – when applied alongside a cap of £35,000 – offers additional protection for those with lower housing wealth (the bottom quartile of homeowners). The extended means test ensures that these people do not have to pay the full £35,000 contribution, which for some could mean losing 60% of their assets. Instead, no one will need to use more than 30% of their assets to pay for care.

**Figure 2.23: Maximum possible asset depletion for people who enter residential care and have lifetime care costs of £150,000**

![Graph showing maximum possible asset depletion for different asset levels with and without caps.](source: Commission analysis)

**Total public expenditure by income quintile**

The figure below shows public expenditure per quintile for the current system and the additional public expenditure for our core recommendations – a cap of £35,000 and raising the upper asset threshold for residential care to £100,000. The quintile points set out below are based on assessed individual incomes of those aged 65 in the PSSRU microsimulation model.

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30 This chart assumes residential care costs of £28,600 p.a. and individual income just sufficient to cover a contribution to general living costs of £10,000 p.a. Housing wealth percentiles relate to homeowners only.

31 Income includes both direct income and income imputed from assets at a rate of £1 per week per £500 of assets.
Figure 2.24 shows that under the current system more than 80% of spending goes to the bottom 60% of the income distribution; around 3% goes to the top 20%. Under our core proposals around 75% still goes to the bottom three quintiles – so the system is still highly progressive. There are two main reasons that relatively little public expenditure goes to the top quintiles. Firstly, those in the upper income quintiles tend to be relatively younger and hence less in need of social care. Secondly, even under our reforms, the bulk of state spending goes through the means-tested system, which targets support at the less well-off.

**Figure 2.24: Public expenditure on social care for older people in 2010/11 – the current system and additional expenditure from reform, by quintiles of older people’s income**

<table>
<thead>
<tr>
<th>Percentile</th>
<th>20th</th>
<th>40th</th>
<th>60th</th>
<th>80th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessable income (£p.a.)</td>
<td>7,800</td>
<td>10,712</td>
<td>13,988</td>
<td>20,124</td>
</tr>
</tbody>
</table>

The costs and benefits of social insurance for each quintile

Our reforms provide partial social insurance against the costs of care to all wealth and income groups. The additional public spending shown in Figure 2.25 can be seen as the cost of providing such partial social insurance to each quintile.

The cost of providing insurance to those in the higher quintiles is higher, because they have more to insure and are more likely to have levels of wealth that exclude them from eligibility for means-tested support. In addition, some people in the lower quintiles already have a significant proportion of their assets insured by the current means test (which...
protects £14,250 of assets fully and assets of between £14,250 and £23,250 partially). As a result, additional state spending is greatest for the top quintile and least for the bottom.

However, cost as a proportion of income is broadly constant across each group, and is slightly lower for the highest quintile group. Figure 2.25 shows the cost per person of providing insurance to each quintile group as a proportion of the mean quintile income.

**Figure 2.25: Additional public expenditure in reformed system in 2010/11 as a percentage of income, by quintile**

![Figure 2.25: Additional public expenditure in reformed system in 2010/11 as a percentage of income, by quintile](image)

Source: ESHCRU/PSSRU microsimulation model

The overall distributional effects of our proposals will also depend on how the additional money to fund them is raised. As discussed, we believe that the Government is best placed to determine how our reforms are funded.

Figure 2.26 shows the mean incomes of, and direct taxes paid by, UK households, by income quintile. Based on this, Figure 2.27 shows the proportion of income that UK households in each quintile would pay were the additional costs of our proposals raised through direct taxation.

This shows that if our reforms were funded in this way, those in the higher quintiles of the population household income distribution would pay greater proportions of their incomes towards the additional costs.
Figure 2.26: Mean annual income and direct taxes of UK households, by quintile\textsuperscript{32}

<table>
<thead>
<tr>
<th>Quintile</th>
<th>Bottom</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>Top</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax</td>
<td>£1,195</td>
<td>£2,200</td>
<td>£4,850</td>
<td>£8,403</td>
<td>£19,500</td>
</tr>
<tr>
<td>Income\textsuperscript{33}</td>
<td>£10,535</td>
<td>£16,933</td>
<td>£24,377</td>
<td>£33,483</td>
<td>£60,388</td>
</tr>
</tbody>
</table>

Figure 2.27: Additional tax paid, as a percentage of income, if reform were funded through direct taxes, by household income quintile

Source: The effect of taxes and benefits on household income 2009/10, Office for National Statistics

Impacts by age

Our proposals will have different impacts on different age groups.

They will have the biggest impact on older people – because the vast majority of younger adult service users currently receive their care for free or at minimal cost to them.

However, younger adults will, of course, benefit from our recommendations. Increasing public expenditure on social care, and reforming the assessment process to make access to care fairer and more transparent, will help to tackle unmet need in this group.

\textsuperscript{32} The effect of taxes and benefits on household income 2009/10, Office for National Statistics.

\textsuperscript{33} Income net of cash benefits and direct taxes.
In addition, our proposals, by placing a cap on their contribution, will benefit those who currently self-fund and those in the means test who will no longer pay charges after the cap is reached. We are proposing that the level of the cap for younger adults is lower than that for older people and should be tiered to reflect the differential ability to accumulate assets by a given age. This ensures that the system is fair for people of all ages.

The number who will benefit in this way will be a relatively small proportion of the total number of younger adults receiving social care. Firstly, there are thought to be relatively few younger adult self-funders compared with the number of self-funders among older people. Furthermore, charging in the means test is relatively uncommon: income from charging is only around 5% of the gross expenditure on younger adults, compared with around 20% for older people. Most younger adults paying charges are in residential care and they will continue to pay a contribution towards general living costs.

For older people, the likelihood of needing care and support increases with age.

Figure 2.28: Proportion of older people unable to perform one or more activity of daily living, and the proportions in receipt of benefits and social care

Sources: General Household Survey (GHS); English Longitudinal Survey on Ageing (ELSA); Department for Work and Pensions; Commission analysis
Our proposals direct extra resources to those who are older, not because of their age but because they are more likely to need care and less likely to benefit from the current means tested system.

The way in which money is raised from the population will also have an impact on different age groups. Some argue that those currently retiring – the baby boomers – are a large cohort who have benefitted from a windfall on their housing asset and a supportive welfare state throughout their lives, whilst the smaller cohort behind them have not had the same benefits. If the money were raised through general taxation, some of those paying for the proposals for older people would not be the current beneficiaries, though they would of course benefit when they became older and were at more risk of needing care and support, and would all immediately benefit from the reduced uncertainty provided by the proposals. We therefore suggest that if general taxation is used to fund these reforms, it would seem sensible for at least part of the burden to fall on those over state pension age.

**Impact by gender**

Women are more likely than men both to need care (see box below) and to be a carer; 60% of carers in England are women.  

We can therefore expect our proposals to have a disproportionately positive effect on women.

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Risks of care need in later life for men and women

Women have a higher risk of future care needs than men due to higher morbidity and longevity (both with and without a disability), and also because wives tend to outlive their husbands.

- 39% of men over 85 have difficulties with one or more ADL compared with 46% of women (Institute for Fiscal Studies analysis of ELSA 2008/09 carried out for the Commission).

- The mean expected future lifetime cost of care at age 65 is £25,000 for a man compared with £44,000 for a woman (PSSRU modelling 2011).

- Women make up 68% of service users aged over 65 (compared with 50% of users aged 18–64; referrals, assessments and packages of care data, NHS Information Centre).

- The probability of survival for five years from the onset of disability\(^{35}\) for women aged over 85 is 50% compared with 25% for men (evidence submitted to the Commission by Professor Jagger\(^ {36} \)).

In terms of supporting people in making their own contribution, the European Court of Justice has recently ruled that insurers can no longer offer gender-specific premiums. This could have a significant impact on long-term care, given the varying probabilities of needing care between men and women. The ruling will come into force on 21 December 2012. It is not within the Commission’s remit to comment on these developments, but the Government and financial services industry will need to consider their impact when considering which products to develop.

Impact by household type

Under the current system, people with the same level of need and wealth but with different household characteristics can have significantly different outcomes.

Marital status

For example, a single homeowner going into residential care has all their housing assets taken into account in the means test and so would expect to have to pay the full care home fee themselves and significantly deplete

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\(^{35}\) Inability to perform at least one of five ADLs without human help: transfer to and from a chair (from interviewer assessment), put on shoes and socks, prepare a hot meal, get around outside, and have a bath or an all-over wash.

their assets over time. Conversely, a homeowner who is part of a couple where their spouse or partner is still living in their joint home would have none of their housing assets taken into account on going into residential care. This reflects the fact that the home is still being used and prevents any requirements on the partner to have to move in order to release assets. But it means that the financial outcomes for the single person compared with the person that is part of a couple can be quite different following a period of care.

The introduction of the cap will significantly reduce the disparity between these two groups, introducing a limit on the amount of asset spend-down that the single homeowner would face in residential care. As noted previously, single people are much more likely to go into residential care than people who are part of a couple, so the group that will benefit is relatively large.

*Housing tenure*

As another example, a renter requiring domiciliary care who has the same value of liquid assets as a homeowner has tied up in their home and the same level of income could face substantially higher charges for domiciliary care. This is because liquid assets can be taken into account in the domiciliary care means test whereas the value of the primary residence is not. With the introduction of the cap, as above, the disparity between the two groups would be reduced such that the renter would face a limit on the extent of their liquid asset depletion to pay towards their domiciliary care. We have suggested that once the cap is introduced, the Government might want to consider taking housing assets into account in the domiciliary care means test. Were this to happen in future then the difference in financial outcomes between the two groups of people would be removed altogether. However, the number of renters with high liquid assets is likely to be relatively small.

*Impacts by region*

The costs of care in any setting vary significantly by region, given differing labour and property costs. For example, the average gross hourly cost of home care/help in Wakefield is £12 while in Windsor and Maidenhead it is £22. The average gross unit cost of a residential place for an older adult in Blackpool is £373 while in Bristol it is £649.37 This means that the cost of local authority packages will vary by region, meaning that under the current, and reformed, system, people face different levels of maximum charges for care depending on where they live. Under our proposals, people will also build up care costs towards their cap at different rates depending on where they live. However, this is an inevitable consequence of a system which meets needs at

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37 Personal Social Services Expenditure and Unit Costs, 2009/10, The Information Centre for Health and Social Care, 2011.
an individual level and reflects local circumstances and conditions rather than attempting to categorise people and apply homogenised service responses.

People’s ability to pay for care will vary by region; for example, the median property price in Burnley in the last quarter of 2010 was £70,000, compared with £490,000 in Camden.\textsuperscript{38} The means-tested support available under the reformed system will ensure that those with lower levels of wealth, wherever they live, will receive support from the state in making their contribution. The increased upper asset threshold in residential care will ensure that those living in regions with lower house values, who have housing wealth in the lower part of the property wealth distribution, will not deplete their housing assets as quickly as they would under the current system, making the system fairer.

\textbf{Impacts by ethnicity}

People of different ethnic groups can have different outcomes under the current care and support system. For example, some may face cultural barriers to accessing care services, such as: the perceived shame and guilt associated with the sense of ‘abandoning’ one’s duty to care for a family member if they were to go into a care home; language barriers; or dietary requirements. Under our proposals, improved information and advice will better support people from different ethnic backgrounds.

People from minority ethnic groups are more likely to be on low incomes, both in working age and in retirement, partly driven by lower levels of economic activity – employment rates are 12 percentage points lower for ethnic minority groups than the overall employment rate (61\% compared with 73\%).\textsuperscript{39} As a result, they are less likely to be able to plan and prepare for future care needs as much as the white population. The impact of our reforms will therefore benefit these groups, as detailed above.

Non-white groups make up 12\% of service users aged 18–64, compared with 4\% of users aged over 65+. This reflects the lower proportion of non-white groups in the total older population than in the total younger population and will gradually change. 5\% of service users age 18–64 are Asian/Asian British and 4\% are Black/Black British. The equivalent proportion for each group of the over-65 service users is 2\%. These groups will therefore benefit proportionately more from our proposals to have a lower cap for younger adults as, under the current system, they would be subject to means testing and could face high costs.

\textsuperscript{38} Communities and Local Government information on local level house prices, 2010.

\textsuperscript{39} Department for Work and Pensions estimate for quarter 4, 2010.
Impacts by religion or belief

People with different religions or beliefs may also face barriers to accessing care services due to, for example, dietary requirements or other religious observances. These issues were mentioned during in-depth interviews that were carried out with faith leaders as part of our deliberative research. Also discussed were barriers around cultural stigmas of ‘abandoning’ family members into care homes and around language, as discussed above.

Given this diversity, it may be that certain groups want to meet their care contribution in different ways. Our proposals have been designed specifically to give people choice over how they meet their contribution. For example, some Muslims have specific requirements from financial products, and therefore it is important that there is choice over how to fund the personal contribution. We are also strongly supportive of the personalisation agenda, and expect that care will continue to be developed via personal budgets and direct payments under our model. This will mean that people will continue to have choice and control over the way in which their care is delivered.

Impacts by sexual orientation

Gay, lesbian, bisexual and transgender groups will benefit from our reforms. We carried out deliberative research with these groups in order to better understand their views. This work, and that of previous consultations, suggests that some are concerned over how they will manage a care and support need, as there may be less unpaid care available from family members. We believe that the introduction of a capped cost system will better support these groups by providing an improved system, and removing fear and uncertainty over future care and support.

The Government would need to conduct a full equalities analysis on the impact of reforms and changes to the adult social care system.

Impact on local authorities, the NHS and others

Local authorities

Local authorities will continue to play a central role in ensuring the delivery and commissioning of care and support services to their local populations. Not only does funding and responsibility for adult social care rest with local government, but local authorities also have responsibilities for housing services and the wider well-being of their local population.

40 Public engagement exploring care and support funding options, TNS-BMRB, 2011.

41 See the summary of the findings from the ‘Big Care Debate’, published in: Building the National Care Service, HM Government, 2010.
Local authorities will continue to assess people presenting with a care need and will assign personal budgets (or a direct payment) to help people meet these needs. For those falling within the means-tested system (and in future those reaching the cap), they will continue to fund the care package. They should also continue to commission (or support individual’s in commissioning), and in some cases provide wider services to support their entire population (e.g. community meal services).

We are supporting the Law Commission’s recommendations that local authorities also have a duty to provide information and advice.

Moving towards a national offer will need to be balanced with local flexibility. We believe that our proposed model leaves local government with sufficient levers to be able to manage their budgets.

Social care is a significant proportion of local authority spending. Figure 2.29 shows that, in 2009/10, net current expenditure on social care was almost 31% of the total annual local authority budget (excluding education and police). This would rise to around 35% were our proposals fully implemented in 2010/11 and were the additional spending routed through local authorities.

**Figure 2.29: Local authority net expenditure by service, 2009/10:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Net current expenditure (£ billion)</th>
<th>Proportion of total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult social care</td>
<td>14.6</td>
<td>30.9%</td>
</tr>
<tr>
<td>Highways and transport services</td>
<td>6.5</td>
<td>13.9%</td>
</tr>
<tr>
<td>Children’s social care</td>
<td>6.4</td>
<td>13.6%</td>
</tr>
<tr>
<td>Environmental and regulatory services</td>
<td>5.3</td>
<td>11.2%</td>
</tr>
<tr>
<td>Cultural and related services</td>
<td>3.5</td>
<td>7.4%</td>
</tr>
<tr>
<td>Central services</td>
<td>3.4</td>
<td>7.2%</td>
</tr>
<tr>
<td>Housing services</td>
<td>2.7</td>
<td>5.8%</td>
</tr>
<tr>
<td>Planning and development services</td>
<td>2.3</td>
<td>4.9%</td>
</tr>
<tr>
<td>Fire and rescue services</td>
<td>2.2</td>
<td>4.6%</td>
</tr>
<tr>
<td>Other services</td>
<td>0.2</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Total service expenditure</strong></td>
<td><strong>47.1</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

We are not proposing any major change to the mechanism by which the Government funds social care. Under our proposals, funding – both for the means-tested system and for those who have reached the cap – could continue to be routed through the local government finance system. We

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42 Local authority revenue expenditure and financing England: 2009-10 Individual Local Authority Data (Revised).
believe that it could be distributed through a specific grant based on a new funding formula without putting pressure on council tax.

The NHS

Our proposals for reforming adult social care could have a significant, and positive, impact on the NHS. It has not been possible for us to quantify the impact, but we believe that a properly resourced social care system will deliver savings for the NHS.

There will always be a funding boundary while there are two different funding systems. However, improving the funding arrangements should lead to services being able to work together better, facilitating improved effectiveness and efficiency. For example, it is possible that we could see quicker discharge from hospital, reduced unnecessary admissions to hospital and people being treated better within the community. Our proposals support the integration of services and pooled budgets – which we believe will pave the way for more effective service delivery.

NHS Continuing Healthcare is a particular area where we believe that there could be a positive improvement, should our recommendations be implemented. Currently, there are many disputes over individual cases – because the financial consequences of being assessed as eligible for NHS Continuing Healthcare can be very significant. Those who are not assessed as being eligible for free NHS care currently have to fund all of their care themselves but, under our proposals, an individual’s maximum liability is capped. This will improve the overall fairness of the system, and could lead to a reduction in the number of disputed cases. Furthermore, we expect that many people who might expect to be eligible for NHS Continuing Healthcare would reach the cap and therefore qualify for free care. Again, this should facilitate professionals in health and social care working more effectively together, in the interests of individuals, families and carers.

Impact on providers and the workforce

Currently we know that there are many people working very hard, providing valuable services across the country. Our expectation is that a better-resourced and more effective social care system should help to improve the overall quality of care.

It is for the Government to take forward work on the quality of services, the development of the market and workforce issues in its forthcoming White Paper (which will bring together our work and that of the Law Commission alongside the Government’s vision).
2.3 Assessing funding models

Summary
We have considered a range of funding models, assessing them against our agreed criteria and the aims we developed through our Call for Evidence. We believe that a system where costs are shared between individuals and the state is preferable to one in which either the state takes all of the costs (free care) or in which individuals take all of the costs unless they cannot afford to do so (the current system).

Of the different ways in which responsibility for the cost of care could be split between the individual and the state, we think that the state capping the cost by setting a limit on the care costs that any individual will have to cover over their lifetime would best achieve our aims and meet our criteria.

Introduction
This section discusses the key arguments that have led the Commission to our conclusion on our preferred funding model. We believe that the best approach is to share responsibility between the individual and the state through a ‘capped cost’ model. In this section, we assess a wide range of different approaches against our aims, and the criteria which we agreed with the Government for judging different models.

How the funding models were assessed
When considering which funding model would form the core of our recommendations, we considered a range of options, with a view to choosing the one that performed best against the criteria we agreed with the Government and the aims developed through our Call for Evidence.

Aims
Our overall objective is to enhance the well-being of individuals, families and carers, supporting people of all ages in achieving the outcomes they want from their lives.

To achieve this overarching objective, the Commission believes that any reformed funding system should:

- offer protection to everyone against the risk of high care costs and be clearer, helping people to plan and prepare and encouraging saving;
• **support everyone in making their personal contribution** by opening up a viable space for financial products, supporting carers and providing targeted state support; and

• **be better aligned with other elements of the care and support system** to form a more streamlined and integrated system where delivery is shaped around individuals, not services.

**Terms of Reference and criteria**

In the Commission’s Terms of Reference, we were asked to examine and provide deliverable recommendations on:

• how best to meet the costs of care through a **partnership** between individuals and the state;

• how people could choose to **protect their assets**, especially their homes, against the cost of care;

• how, both now and in the future, **public funding can be best used** to meet care and support needs; and

• how the preferred option **can be delivered** in the context of local government, the NHS and financial regulation.

In addition to these aims, the Terms of Reference state that ‘the Commission should judge funding models against set criteria, which it should agree, and present to Government for approval, within the first two months’.

Five criteria were agreed with the Government:

1. **Sustainable and resilient**: ensuring that the costs to the state are sustainable in the long term, and the care and support system is able to respond to demographic, economic, political and societal change.

2. **Fairness**: for individuals, families, carers and wider society.

3. **Choice**: offering an affordable choice to individuals, carers and families across a range of care settings, and helping people to prepare and plan for their future.

4. **Value for money**: securing the highest quality care outcomes with the available resources.

5. **Ease of use and understanding**: making the system as clear and simple as possible for people, supporting people to take responsibility for their future well-being.
Along with these criteria, the Commission specified two underlying principles which must underpin any care and support system:

- **Promotion of the well-being of individuals and families** – enabling people to maintain their dignity, protecting those in the most vulnerable circumstances and helping everyone to participate in the wider community.

- **Recognition of the valuable contributions of everyone involved in care and support**, including individuals; carers and families; volunteers and professional carers; private, public and charitable sector organisations; taxpayers; and wider society. As outlined in the Terms of Reference, our recommendations cover all adults in England – working-age and older people.

The funding of care and support should be a shared responsibility between the individual and the state

The costs of care and support in England are already significant, and will grow with demographic change. In looking at how to fund care in the future, there are three possible broad approaches:

1. **The individual meets all their own care costs.**

2. **The state meets all care costs.**

3. **The costs are shared between the individual and the state.**

Each of these three approaches is discussed below.

1. **The individual meets all their own care costs**

   The current social care system leaves individuals responsible for their own care costs, unless they cannot afford these costs, in which case they are supported by a means-tested system. It could be argued that care costs should remain the responsibility of the individual, but the current system illustrates a number of problems with this approach.

   The main strength of leaving care costs to the individual (for those outside the means test) is that the costs to the state are low compared with other systems, with state support targeted only towards those with the lowest means, and then within that group, those with high needs.
Social care for those over age 65 makes up only 6% of overall state spend on older people (including pensions, benefits and health spend for the over-65s). However, this comes at a cost of unmet need – care and support needs which are not met by either paid or unpaid care. It also places costs on carers who can often have a significant gap to fill. So while resources in the current system are targeted by means, we do not believe that they are well targeted by care need as many people with significant needs, and their carers, do not receive any state support.

The other key weakness of this system is that there is very little people can do to protect themselves against the possibility of very high care costs. Many people perceive it as unfair that some people have to sell their homes, or use up the majority of any assets they have, to pay for their care, while others may not have to pay anything.

Lifetime care costs are highly variable. At age 65, a quarter of all people can expect to have little or no formal care costs over the remainder of their lifetime. At the other end of the scale, a quarter can expect care costs of over £50,000, one in ten can expect costs over £100,000 and one in every hundred people can expect cost of more than £270,000 on care.

It is not possible for a person to predict with any certainty where they will be in this distribution, so – in the absence of insurance options – a 65-year-old has two options: they either accept that they run the risk of spending all of their assets on care and then falling into the means-tested system; or they attempt to plan for the possibility of very high care costs through saving.

If a person wanted to ensure that they did not fall into the means-tested system, our evidence suggests that people might have to save in excess of £270,000 in current prices (2010/11) to pay for care. This is not feasible for most people, and would also be hugely inefficient: only one in every 100 people will actually need that amount, while in retrospect the other 99 would have been better off spending that money on other things.

The role of insurance in helping individuals to manage risk
For any other activity which has this type of risk, people are able to buy insurance, or be covered by tax-funded social insurance. For example, few of us could afford to replace our home in the unlikely event that it burnt down, but we are able to pool that risk by buying insurance. Similarly, few of us could afford the latest medical treatments if we developed a life-threatening illness, but, through the NHS, we pool this risk so that those unlucky enough to fall ill can have access to healthcare.
We also insure against the risk of living longer than our savings would allow for by buying annuities with our pension savings – where the shape of the distribution of possible outcomes at age 65 is less skewed than that for future care costs (see below).

**Figure 2.30: Distribution of expected living costs aged 65, by percentile**

![Distribution of expected living costs aged 65, by percentile](source: Commission analysis of English Life Tables No. 16 2000-02, Office for National Statistics)

The efficiency and equity arguments for risk pooling – be it privately or publicly provided – are well documented in economics literature. The box below uses a worked example to show why it is more efficient to join a risk pool to cover future care costs than to save up enough to cover the worst possible outcome.

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1 Costs are expressed in 2010/11 prices

The benefits of insuring against the cost of care and support

The worked example below illustrates the benefit to the individual of risk pooling.3

Assume that 25% of people over 65 years of age need intensive care and support, costing £30,000 a year, for an average 2 years. Also, assume that the maximum duration of needing this care is 20 years.

In principle, there are two ways in which a person could seek to finance such costs – by self-insuring or by buying insurance:

- In a world of no insurance (i.e. no risk pooling), a person who seeks total protection must save enough to cover the maximum potential duration of long-term care. This would be 20 years at £30,000 per year = £600,000.
- If they bought insurance (i.e. risks are pooled) at a fair price they would need to save enough to cover the average duration of care. This would be 2 years, at £30,000 per year with a probability of 25%. In total, this would mean spending £15,000 (excluding administration costs).

With risk pooling in place, people who wanted to protect themselves would not have to save £600,000. Instead they would pay an insurance premium of £15,000.

With a functioning, actuarially fair insurance mechanism, joining a risk pool and paying premiums will involve a much lower cost than self-insuring. Insurance therefore frees up the income and wealth of risk-averse individuals, allowing them to smooth their consumption over time without need for substantial precautionary savings, and thus improving their well-being in later life.4

As well as the direct financial advantages, insurance gives people peace of mind: individually they would no longer have to worry about the financial implications of needing a significant amount of care and

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4 In modelling household consumption and savings behaviour in the UK and elsewhere it is common to take account of the impact of uncertainty. Many empirical studies have demonstrated the importance of risk aversion and precautionary savings motives in determining life-cycle consumption patterns. See Understanding Consumption, Deaton A, 1990, for a survey of the extensive literature, or ‘Risk pooling, precautionary saving and consumption growth’, Banks J, Blundell R and Brugiavini A, Review of Economic Studies, 2001; 68(4): 757–779, for specific empirical evidence from the UK.
support later in life. Furthermore, if we assume that the distress sale of a home to fund care is seen by consumers as a ‘loss’ among the range of expected outcomes in later life, then assuming some degree of loss aversion in the population, insurance against care costs will be deemed beneficial.

While behavioural effects of this type of financial risk are difficult to quantify and we lack direct evidence on the saving and expenditure decisions of those with care and support needs, it would be rational for a person who is faced with these potentially catastrophic lifetime costs to be less inclined to buy care when they first develop a care need. The longer a person waits before initiating formal care the lower their lifetime cost will be, and there is potentially a lot to gain financially by going without instead of spending money. Anecdotally this seems to be true: the threat of extreme financial costs leads to many people who need care not getting it.

The insurance industry is unable to provide attractive products that manage this risk

Under a care and support system where the individual has responsibility for their care costs, it is reasonable to look to the insurance industry to provide products that pool financial risk so that no one is exposed to the very high costs outlined above.

However, a combination of demand- and supply-side problems has left the insurance industry unable to provide attractive products, and there are currently no major financial services providers offering pre-funded insurance against care costs in the UK. This implies a loss of welfare and the existence of a market failure.

The barriers to provision include the existence of uncertainty rather than risk, potential non-independence of outcomes and adverse selection. No country in the world has a functioning pre-funded long-term care insurance market that has broad coverage across the population and offers coverage of 100% of costs. Providers do not know what the probability distribution of care costs will be for future cohorts of older people and have struggled to design products which are flexible enough to deal with the uncertainties, yet are still attractive to consumers. When products have come onto the market they have been

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expensive and subject to changing premiums or benefits and, without a full recognition of the risks that they face, people have seen them as poor value.

Private providers also find it difficult to hedge against non-independent risks such as a medical advance changing the outcomes for a large majority of insured individuals, and face issues of adverse selection which could cause premiums to escalate, affecting the level of demand.

These issues are discussed further in Section 3.3 on the role of the financial services sector.

2. The state meets all care costs

One response to the problems of the current system would be for the state to take full responsibility for care costs. All care would be funded through general taxation or a compulsory levy, and provided free at the point of use – as we provide healthcare through the NHS. This would require significant additional state spending, and experience from other countries shows that it might not be sustainable.

The key advantage of the state meeting all care costs is that the risk of high care costs would be pooled across the entire population and no one would be exposed to extreme financial risk.

Care needs in later life have been demonstrated to be needs that could efficiently be covered by risk pooling, but the private sector financial services industry has not offered a solution. Therefore, welfare could be improved with the state taking on the role of risk pooling. This could be seen as a fair solution as, regardless of condition or type of need, people would be protected, getting care free at the point of use. In particular, care needs that begin early in life cannot be prepared for by any individual or family and so are uninsurable except at a societal level. The system would also be clear as the funding divide between the care and support system and the NHS would be removed.

Free care could also provide greater opportunities than under a mean-tested system for people to access information about care services, as almost everyone who needed care would come into contact with the state.

Meeting all care costs is of course the most expensive option that the state could choose. Modelling carried out on behalf of the Commission by PSSRU and PSSRU/University of East Anglia suggests that, in order

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7 Where only those who knew that they were more likely to need care would demand insurance but the insurer, without access to that information to enable it to discriminate among purchasers, would have to set higher premiums in response to higher payouts.
to provide care for older people that is free at the point of use, the state would need to spend an additional 0.3% of gross domestic product (GDP) (£3.8 billion) in 2010/11, rising to 0.47% of GDP in 2025/26 (£7.7 billion, 2010 prices). Social care spending in 2010/11 would be around 60% higher than under the current system and 70% higher in 2025/26.

These are the additional care costs only – and exclude general living costs of £10,000 p.a. in residential care and the additional costs of assessment. If general living costs were also free as part of the social care system, the total cost of the system would be an additional £6.2 billion in 2010/11 – almost a doubling of current costs. These cost estimates do not allow for additional demand which would arise from an offer of free care.

**Free care would be neither sustainable nor resilient**

While the costs of different care systems can be estimated with some confidence today, costs in the future are much more uncertain due to changes in demographics, behaviours and expectations. One issue is that the costs of a free care system are at risk of being increased on implementation due to behavioural effects. The existence of a ‘free’ service could encourage more people to step forward to try to get access to this service than would have otherwise been the case, and could cause people to try to negotiate a larger-sized package than they would have done had they needed to bear some of the cost themselves.

Research following the introduction of free personal care in Scotland, for example, found that the increase in demand for personal care was substantial and cannot be explained by demographic trends, higher rates of disability or reductions in informal care.8

In order to have a funding model that is resilient to both cost and wider societal changes, it is important that the system has sufficient levers to allow the Government to control costs without undermining the system itself. People need to have confidence that the system will look, in future, broadly as it does today so that they can plan and prepare appropriately.

Experience in other countries, such as Germany and Japan, which have recently reformed their social care funding models, demonstrates the vulnerability of a free care system to a changing economic and political environment.9 In both of these countries, social care costs rose more quickly than had been predicted or governments were willing

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8 *Free Personal Care in Scotland: Recent developments*, Bell D, Bowes A and Dawson A, Joseph Rowntree Foundation, 2007

to sustain, and both governments adjusted their systems – by making them less generous – to control these costs. This then went some way to undermining the promise of free care as people were still exposed to significant costs. Free care is not in our judgement a resilient proposal.

3. Costs are shared between the individual and the state
Given the inadequacies of a system which leaves costs to individuals (such as is the case with the current system) and that providing all care free at the point of use is unlikely to be sustainable or resilient, we believe that we need a system which shares the cost of care between the state and individuals.

There are different ways in which costs could be shared, and these are assessed in detail in the next section. A model is required that can address the key problems of the current system – that people are left exposed to very high care costs and have significant disincentives to meet their care needs – while having sufficient levers to control costs without undermining these benefits.

Choosing the optimal model of shared responsibility
We consider two models for sharing responsibility for the costs of care and support:

• The ‘capped cost’ model
The state sets a limit on the care costs that any individual will have to cover over their lifetime from onset of their care need. If the individual has had care needs equivalent to this cost, the state will cover all subsequent care costs. This can be thought of as social insurance with a significant excess.

• The ‘shared cost’ model
The state and individual each pay a proportion of all care costs over time. The price that an individual pays for care at the point of need is effectively reduced compared with the current system.

There are a number of other possible ways in which responsibility for the cost of care could be split between the individual and the state, but which would not meet our aims and objectives.10

10 For example, the state could pay for everyone’s care initially, but only up to a maximum cost. After this point, the individual would be required to fund their care privately. This would leave more gainers in a direct financial sense than other models, and would probably lead to more people consuming care services when they first develop a care need. However, it would not allow people to protect their assets, and would do little for those with the greatest need, meaning that resources would not be well targeted. It would also have the potential to create significant demand effects. We have therefore concluded that this would not be a sensible approach given our aims and objectives.
The capped cost model

Our recommended model for the division of responsibility between the individual and the state is for the state to limit the costs to which an individual is exposed. Under this model, individuals are initially responsible for meeting all of their care costs. However, once their accumulated costs reach a certain level, the state will meet all of their remaining care costs.

The capped cost model allows people to protect their assets

By explicitly capping the costs that individuals can face over their lifetime, this model puts a clear limit on the amount of a person’s assets that could be depleted as a result of a care need. The Commission has concluded that the cap should be set between £25,000 and £50,000. We believe that a cap of £35,000 is fair and appropriate, and have used this as the figure for the cap throughout this report.

The figure below shows how the lifetime care costs to which people are exposed under a capped cost model (assuming a £35,000 cap) compare with the equivalent costs under the current system.

Figure 2.31: Lifetime care costs met by the individual under the current system and a capped cost model, for people who do not qualify for means-tested support, by percentile

Source: ESHCRU/PSSRU microsimulation model

11 This chart assumes a cap of £35,000 and looks only at people who enter care, ignoring the quarter of 65-year-olds who can expect to need little or no formal care. The effect of the means test is not shown – in practice some people would receive additional help in making their contribution. Costs are adjusted for care cost inflation and presented in 2009/10 care prices, to reflect the effect of a cap that rises in line with care costs.
The need for a clear, capped offer is supported by results from deliberative research undertaken by the Commission. This work suggests that people are attracted to the capped cost model because:

- it puts a limit on the costs that they will have to pay;
- it protects a proportion of income and assets;
- it provides peace of mind; and
- having a ‘known quantity’ of cost enables people to prepare and provides an incentive to plan.

Recent polling carried out for the Commission also found that 51% of 35–54-year-olds are concerned about covering the costs of their care in older age (compared with 36% who are not concerned and 13% who have not thought about it).

The capped cost model provides broad benefits while also targeting support on those with the highest needs

The insurance benefits of the model accrue to those not already receiving free care, improving their well-being by removing the fear surrounding care costs and removing the need to self-insure through saving for costs in excess of the cap. The model targets those with the highest needs over their lifetime – because these will be the people who reach the cap and are then supported by the state. It therefore meets both the value for money and fairness criteria.

The capped cost model could encourage people to buy the care they need

The capped cost model reduces the long-term cost of meeting a care need, and in doing so removes a significant disincentive for a person to buy care – namely that buying care might ultimately lead to the depletion of most of their wealth. This could generate an increased propensity to spend on care which would reduce unmet need, improving individuals’ well-being and that of their carers.

In the longer term, this could also have the effect of reducing costs to the NHS if individuals and their carers are better supported through the care and support system. The King’s Fund notes, in recent work on trends in social care spending, that there is ‘promising evidence that spending on the right kinds of social care can reduce inappropriate use of NHS resources’.

12 Deliberative research was undertaken for the Commission by TNS-BMRB. The full report has been published alongside this report.

13 Polling undertaken by TNS-BMRB (2011) for the Commission.

In providing insurance against future care costs to all, with an excess, the state takes on additional care spend. This will inevitably mean that some people will get state support who previously would have provided for themselves. However, the existence of the cap ensures that older, wealthier individuals will provide for themselves up to the cap, and most people’s needs will not be high enough for them to need to rely on state support beyond the cap. Modelling suggests that around two thirds of people over 65 who end up needing some care will not reach a cap of £35,000.

**The capped cost model provides opportunities for the financial services sector**

As has been discussed, the financial services sector has struggled to provide attractive pre-funded long-term care insurance products for the tail-end or catastrophic risk. Under the capped cost model the state takes on this role, creating a space for the private sector to offer different types of product alongside the state offer. With a realistic cost to plan for, people may wish to use existing savings vehicles, such as pensions, ISAs and housing. Disability-linked annuities or top-up insurance (for people who want to have more expensive accommodation than the state will offer) might also become attractive options.

The capped cost model does not rely on the financial services sector to help people to plan for their care costs, but such products could provide people with additional ways to plan and prepare. The cap allows them to manage their own spend much more easily than under the current system, and they could meet their contribution using a combination of savings, financial and insurance products and informal care that is appropriate to them and their family.

The role that the financial services sector could play in a reformed funding system is discussed in Section 3.3.

**Effects on demand for state-funded care**

In addition to demand for private care services, the cap could have an impact on demand for state-funded services. Any extension of entitlements can lead to an increased demand, and there might also be a concern that, by reducing the costs of care to individuals, people might take fewer precautions.

However, these potential demand and moral hazard effects are addressed by the existence of the cap. Since support from the state comes only after the individual has paid for the first £35,000 of care, and has also passed an assessment, potential incentive problems are much reduced.
The shared cost model

A related model which has also been discussed is for the state to meet a proportion of all care costs, thereby reducing the cost of care faced by individuals. A version of this approach was proposed by Sir Derek Wanless in his 2006 report, *Securing Good Care for Older People.*

The shared cost model could encourage people to buy the care they need

One of the main arguments for this model is that it reduces the cost of care at the point of use, and so might encourage people to consume an appropriate amount of care. While behavioural effects such as this are difficult to predict or quantify, it seems likely that, if each person has a certain willingness to pay for care, reducing the cost would encourage more people to buy care.

Variations of this model, including the ‘matched payment’ proposed by Sir Derek Wanless and the King’s Fund, can provide additional incentives for people to consume care and reduce unmet need.

However, we believe the continued risk of very high long-term costs (see below) would undermine this effect. With the possibility of high lifetime care costs, individuals might be reluctant to buy the care they need, even at a reduced price.

The shared cost model provides something to everyone who needs care

In the shared cost model, everyone who needs care gets something from the state to help to meet their costs. On the other hand, the model provides help to people with low levels of need as well as high levels of need, and might not target help sufficiently on those with the highest needs.

Commission analysis of PSSRU modelling suggests that, for an equivalent cost to the state of a £35,000 cap, under a shared cost approach the state could take around a third of the costs that people face while individuals would take the remaining two-thirds. For the equivalent cost of a £50,000 cap the state could take around a quarter of costs and for a £25,000 cap the state could take around half of individuals’ costs.

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15 *Securing Good Care for Older People: Taking a long-term view*, Wanless D, King’s Fund, 2006.

16 Setting aside the impact of means-tested support here on the proportion of costs taken by the state for lower income individuals.
Were the state to take half of the costs, PSSRU modelling suggests that the total (public and private) annual spend on care (excluding top-up spend\(^{17}\) and any other changes to the system) would be the same for older people as under a £35,000 cap (£14.2 billion). But under the shared cost approach that would be made up of some £450 million more public spend and some £460 million less private spend than under the £35,000 capped cost model.

**The shared cost model is resilient**

This model could be resilient to cost pressures. If costs increased more quickly than expected and the state needed to take some action to control costs, it could, within reason, reduce the contribution that it made. If the cost pressures were lower at a later date, the state could increase its contribution again.

**The shared cost model does not allow people to protect their assets**

The major weakness we have observed of the shared cost model is that it does not protect people against very high costs or protect their assets. By reducing all care costs by a fixed proportion, the shared cost model still leaves people exposed to the risk of very high costs over their lifetimes. Under the shared cost scenario that costs the same to the state as a £35,000 cap where the state takes around a third of care costs, a quarter of all 65-year-olds could still expect to pay care costs of over £35,000 themselves, one in ten more than £66,000 and one in every hundred more than £180,000 (in 2010/11 price terms).

These costs are still too high for most people to plan or prepare for, and some would still lose the large majority of their assets, including their homes. The figure below shows how the distribution of lifetime care costs to which individuals would be exposed compares with the current system, for people who do not qualify for the means test.

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\(^{17}\) Spend over and above that which would be required to fund the care package deemed appropriate by the local authority.
Figure 2.32: Lifetime care costs met by the individual under the current system, and the shared cost and capped cost models, for people who do not qualify for means-tested support

In his classic 1963 article, Arrow uses economic theory to analyse the choice between full insurance with an excess and insuring only a proportion of risk but without an excess. He demonstrates that, for a risk averse individual aiming to maximise their expected future well-being, it is preferable for them to choose insurance with a cover for 100% of uncertain costs over a certain limit, compared with choosing coverage of some proportion below 100% of the costs and no limit.

Under the shared cost model, people are still left exposed to very high costs, which also means that the financial services sector would have many of the same problems it currently has in delivering successful insurance products (as discussed above) to cover the remainder of people’s risk. Whilst the proportion of costs faced may have some certainty attached to it, the value of the remaining proportion would still be subject to uncertainty (as opposed to risk), and would therefore be difficult to insure against. It is our view that this makes it unlikely that new products and markets would develop on a large scale, meaning that it would still remain difficult for individuals to plan and prepare for their later life, and they would still be exposed to the fear and uncertainty that is such a problem with under the current system.

18 This chart assumes a cap of £35,000 and looks only at people who enter care, ignoring the quarter of 65 year-olds who can expect to need little or no formal care. The effect of the means test is not shown – in practice some people would receive additional help in making their contribution. Costs are adjusted for care cost inflation and presented in 2009/10 earnings terms, to reflect the effect of a cap that rises in line with care costs.


20 This assumes that the insurer (in this case the state) is not risk averse.
Assessment of shared responsibility models against the aims of the Commission and the agreed criteria

The aims of the Commission

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<tr>
<th><strong>Capped cost</strong></th>
<th><strong>Shared cost</strong></th>
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<tbody>
<tr>
<td>i. Offer protection to everyone against the risk of high care costs and be clearer, helping people to plan and prepare and encouraging saving.</td>
<td>The capped cost model offers full protection against high care costs, while supporting people to sensibly plan for how they will make their own contribution.</td>
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<td></td>
<td>Everyone still faces the open-ended risk of having very high care costs. Individuals do not have a clear idea of how much money they will need to contribute.</td>
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<tr>
<td>ii. Support everyone in making their personal contribution by opening up a viable space for financial products, supporting carers and providing targeted state support.</td>
<td>Putting a limit on the overall costs opens up a new space for financial products. Underpinning the system would continue to be means-tested support.</td>
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<tr>
<td></td>
<td>A shared cost model would provide everyone with some support in meeting care costs, and could lead to reduced unmet need. But people would not have a clear financial target to plan for, and the financial services sector would find it difficult to promote products.</td>
</tr>
<tr>
<td>iii. Be better aligned with other elements of the care and support system to form a more streamlined and integrated system where delivery is shaped around individuals, not services.</td>
<td>Both models are able to support greater joined-up and integrated working.</td>
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<td></td>
<td>Boundaries between different ways of funding care and support (e.g. between a free at the point of need health services and social care) will also remain under each model.</td>
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The Terms of Reference of the Commission

The Commission was asked to design a system that:

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<th>Capped cost</th>
<th>Shared cost</th>
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<tbody>
<tr>
<td>i.</td>
<td>meets the cost of care through a partnership between individuals and the state;</td>
<td>Both of these models are a partnership between the individual and the state</td>
</tr>
<tr>
<td>ii.</td>
<td>allows people to protect their assets;</td>
<td>Explicitly limits the costs that individuals can face.</td>
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<td>iii.</td>
<td>uses public funding in the best way to meet care and support needs; and</td>
<td>Leaves people still exposed to very high care costs.</td>
</tr>
<tr>
<td>iv.</td>
<td>can be delivered in the context of local government, the NHS and financial regulation.</td>
<td>Targets support at those with the greatest need.</td>
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<td></td>
<td></td>
<td>Gives everyone an equal level of support as a proportion of their need.</td>
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Both of these models have similar implementation issues.
## The agreed criteria

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<th>Capped cost</th>
<th>Shared cost</th>
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### 1. **Sustainability and resilience:** ensuring that the costs to the state are sustainable in the long term, and the care and support system is able to respond to demographic, economic, political and societal change

- If costs rise more quickly than expected, the Government can change the level of the cap, within reason, without undermining the system.
- There would be an expectation that the cap would be adjusted regularly to take account of changing costs, economic circumstances etc.

### 2. **Fairness:** for individuals, families, carers and wider society

- Support is targeted on those with the greatest need over their lifetime.
- Everyone pays an equal proportion of their care costs.

### 3. **Choice:** offering an affordable choice to individuals, carers and families across a range of care settings, and helping people to prepare and plan for their future

- This model offers people choice in how they meet their capped contribution. In opening up a space for the financial services industry, products could be provided that give people even greater choice. By limiting the costs that individuals can face, this system gives people the chance to plan and prepare.
- People could choose how to make up the remainder of their cost, but this system does not give people the opportunity to plan for their future, as they are still exposed to open-ended care costs.
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<th>4. Value for money: securing the highest quality care outcomes with the available resources</th>
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| **For £1.25 billion, costs could be capped at around £35,000, for £1.7 billion, costs could be capped at around £25,000, for £0.8 billion, costs could be capped at around £50,000.**  
By targeting support on those with the greatest lifetime need, this system uses money where it is needed most. Some state funds would be spent on people with high lifetime need who perhaps could have afforded care anyway.  
For £1.25 billion, the state could take around a third of costs with individuals taking two-thirds, for £1.7 billion, the state could take around half of costs, and for £0.8 billion, the state could take a quarter of costs with individuals taking three-quarters.  
This approach would still involve significant contributions from individuals to care costs (e.g. a £12,000 per year contribution in a residential home under the one-third/two-thirds share approach).  
Some state funds would be spent on people with relatively low lifetime need. |
| 5. Ease of use and understanding: making the system as clear and simple as possible for people, supporting people to take responsibility for their future well-being |
| **The cap provides a clear offer from the state. People will have a clear target to aim for – our research indicates that people like this.**  
This system will require people’s care costs to be metered, which adds some complexity.  
**It is easy to understand ‘the state pays x% of your costs’, although the uncertainty over how long those costs might be required generates a complication.**  
Costs would need to be measured for everyone in order to be shared, which adds some complexity. |
The two underlying principles which the Commission believes must underpin any care and support system

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<tr>
<th>Capped cost</th>
<th>Shared cost</th>
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<tr>
<td><strong>I. Promotion of the well-being of individuals and families</strong> enabling people to maintain their dignity, protecting those in the most vulnerable circumstances and helping everyone to participate in the wider community</td>
<td>By removing the threat of very high costs, it is hoped that this system would encourage people to access the care they need.</td>
</tr>
<tr>
<td>By with a capped cost system sitting alongside means-tested support and universal disability benefits, all are protected and helped to participate in the wider community.</td>
<td>By reducing the cost of care, it is hoped that this system would encourage people to buy the care they need. However, this might be undermined to some degree by the remaining threat of very high costs in the longer term.</td>
</tr>
<tr>
<td>Again, protection could be offered if the model sat alongside means-tested support and universal disability benefits.</td>
<td></td>
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</tbody>
</table>
II. Recognition of the valuable contributions of everyone involved in care and support, including individuals; carers and families; volunteers and professional carers; private, public and charitable sector organisations; taxpayers; and wider society.

As outlined in the Terms of Reference, our recommendations will cover all adults in England – working-age and older people.

<table>
<thead>
<tr>
<th>Capped cost</th>
<th>Shared cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>By making planning and preparing for meeting care needs a more realistic prospect, this model could reduce the pressure on families to provide informal care as a way of protecting their assets.</td>
<td>By paying a proportion of all care costs, this model makes no distinction between people of different ages. It would therefore need to be flexed for younger adults who have not had the chance to plan and prepare.</td>
</tr>
<tr>
<td>The capped cost will need to be flexed for younger adults, who have not had the chance to plan and prepare.</td>
<td>With everyone getting some support in meeting their care costs, this could increase the propensity to spend on care, which might reduce the pressure on carers. However, carers may feel obliged to do more than they reasonably can, to mitigate the risk of very high care costs over time.</td>
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Part 3:
Enablers of reform
3.1 The wider care and support system

Summary

To enable the care and support system to work more effectively, the Commission believes that the Government should consider the following:

• How to better align different funding streams, so that people are supported more effectively at critical moments in life, notably on:
  – health, in particular on NHS Continuing Healthcare and end-of-life care; and
  – benefits, in particular on disability-related benefits such as Attendance Allowance.

• A more strategic approach to service delivery, which encourages better integration and joint working between services (notably between social care, health and housing).

• How to encourage people to act early when they are developing or at risk of developing a care and support need, and to invest in activities which may prevent needs occurring or slow their escalation.

Introduction

In analysing how best to reform the funding of adult social care, the Commission decided that it was necessary to take a broad view of care and support. It is not within our remit to provide specific recommendations on reforms to the NHS or the social security system; however, where there are clear interactions and overlaps with the adult social care system, the Commission has examined how the different systems could work more effectively together.

Currently, services often fail to join up, leading to poor customer experiences and frustrations between professionals. There is confusion over roles and responsibilities, and boundaries between different services can seem artificial and are sometimes perceived as unfair. This is particularly the case for people sitting on the divide between the NHS,
which is free at the point of need, and social care, where state support is means tested. It is also unlikely that the state is getting the best value for money as a result of inefficiencies at these boundaries. For example, we know that there are people who are currently in expensive hospital beds, who could be supported better, and more cheaply, with social care support in their own homes.

In this section of the report, we outline a broad direction of travel. We do not recommend detailed changes to the wider system, but instead strongly urge that the Government should consider – as it takes forward its programme of reforms in social care, the NHS and the benefits system – how services can be more coherently aligned in the future. We believe that there is scope to improve quality and deliver savings if the overall system is viewed more strategically.

**A coherent approach to national policy making**

At the national level, the Commission believes that there should be a more aligned approach to policy making across health, social care, public health, social security and housing. Overall, the state spends around £140 billion on older people in England. Of this, social care represents around 6%, the NHS 35% and social security benefits (including the state pension and disability benefits) 59%. It is important that we look at the funding for adult social care within this context.

**Figure 3.1: Estimated public expenditure on older people in England, 2009/10**

![Figure 3.1](image)

Sources: Department of Health; Department for Work and Pensions; Commission analysis
Central governments’ policies in this area have often appeared disconnected. We would encourage successive governments to look at the care and support system as a whole and consider how changes in one area affect other areas.

The Commission welcomes the development of the quality framework for social care, and its close linkages with that of the principles of the NHS quality framework. Over time, the Commission hopes that this will drive more integrated working, for example through the development of more joint quality standards for health and social care by the National Institute for Health and Clinical Excellence (NICE). Government may also wish to consider whether the outcome frameworks for health, public health and social care can be more closely tied together so that everyone within the system is working towards shared outcomes.

**Social care and the NHS**

The NHS is facing many of the same issues as social care – demographic change, the need for greater efficiency, a greater focus on outcomes and the delivery of more personalised services. As a result, objectives often align: people should be treated in the most cost-effective settings, the need for formal services should be avoided and needs should be prevented from arising in the first place, or escalating, whenever possible.

In this section, we look at the relationship between adult social care and the NHS from two angles. Firstly, we look at how the funding of the two systems can be better aligned, focusing in particular on NHS Continuing Healthcare, end-of-life care and re-ablement. We then go on to look at how the delivery of services could be more joined up and shaped around individuals.

**Aligning funding**

Care and support is a spectrum – some people have intensive health needs, some have both health and social care needs, some only need support with certain activities, like washing. Drawing a line between what is a health need and what is a social care need is always going to be a matter of judgement and will involve making difficult decisions.

We know that decisions on who funds services are often linked to the setting in which care is provided. In the past, many older people would have been cared for in long-stay beds, in geriatric wards. Over time, there has been a move towards supporting people in the community, as this should deliver better outcomes and better reflect people’s wishes. However, it has been argued by some that this move has led the NHS to shift its funding responsibility onto individuals and the social care system. On the other hand, people with learning disabilities are also now cared
for primarily through the social care system, although often within an integrated team with health. Many believe this to have been a positive move, as it means that there is a greater focus on helping people to meet their individual goals and aspirations.

The Commission recognises that the boundary between health and social care will always remain while there are two separate funding models. As we have rejected a fully free at the point of need social care system, and recommended a shared responsibility model, the two parallel funding systems will continue to operate. However, we believe that limiting the overall contribution that an individual has to make helps in managing the social care/NHS interface. Free care for those facing the highest costs reduces the sharp distinction in funding between the two systems. Furthermore, we have been clear that the funding of the adult social care system should not encourage any particular care setting and that people should be free to choose to receive care in the way that suits them best.

**NHS Continuing Healthcare**

NHS Continuing Healthcare is a package of care (health and personal care and accommodation costs) arranged and funded solely by the NHS for people who have been assessed as having a primary health need. NHS Continuing Healthcare can be provided in a range of settings, including care homes, or a patient’s home.

If someone isn’t eligible for NHS continuing healthcare, but they are in a nursing home (a care home that is registered to provide nursing care) they may be eligible for NHS-funded nursing care. This means that the NHS will pay a contribution towards their nursing home fees, often known as the Registered Nursing Care Contribution (RNCC).


NHS Continuing Healthcare clearly sits at the boundary between health and social care. For those with extensive needs, but who are not assessed as eligible for NHS Continuing Healthcare funding, it can seem very unfair (although some might still benefit from the NHS funded nursing...
Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support

care contribution\textsuperscript{1}). Indeed, that unfairness was frequently raised in submissions to the Commission as it gathered evidence. The Commission therefore decided to look at how the two systems interact, while recognising that NHS organisation lies outside its terms of reference.

We believe that our recommended changes to the social care system will bring some improvement to this problematic boundary. Many fight for funding under the NHS Continuing Healthcare arrangements, where care is provided free irrespective of people’s means, because the alternative could be funding their care themselves under the social care means-tested system. The financial consequences for two people, with very similar needs and means, can be very different depending on which side of the boundary they are deemed to fall.

Under our recommended arrangements, anyone meeting their needs with social care will have a limit to their total financial exposure, so although there would still be a financial advantage to being assessed as eligible for NHS Continuing Healthcare, the difference would be far less than under today’s arrangements. However, we understand that there will continue to be people with health needs who will not be assessed as having primary health needs (and therefore would not be assessed as eligible for NHS Continuing Healthcare), who may continue to view the arrangements as unfair.

We are strongly supportive of the recommendations of the Law Commission\textsuperscript{2} in this area. The Law Commission sets out proposals for establishing in regulations an eligibility framework for the provision of NHS Continuing Healthcare, and to specify what combinations of needs establish a primary health need, whereby the person would become eligible for NHS Continuing Healthcare. Such reforms will put NHS Continuing Healthcare on a much firmer statutory footing and should help to make the system more consistent and transparent.

Improving the consistency and clarity of NHS Continuing Healthcare
The number of people receiving NHS Continuing Healthcare has been growing over time: in 2007, there were around 30,000 people receiving NHS Continuing Healthcare; in 2010 there were over 50,000. The available data suggest that expenditure by primary care trusts (PCTs) on NHS Continuing Healthcare was in the region of £2 billion in 2009/10. The Commission has been unable to obtain robust analysis on the breakdown of this spend by client or age group.

\textsuperscript{1} NHS-funded nursing care is only used to pay for the costs of nursing care. People who get it will still need to pay for their accommodation, board and personal care, or have a local authority assessment for social care. NHS-funded nursing care is currently £108.70 per week in England.

\textsuperscript{2} Adult Social Care, Law Commission, 2011.
The National Framework for NHS Continuing Healthcare⁴ (introduced in 2007 and revised in 2009) was developed by the Department of Health as a result of a number of legal challenges and Health Ombudsman reports. It set out a single set of national eligibility criteria, with the decision-making processes set out in directions from the Secretary of State for Health.

The evidence suggests that the revised National Framework has added some clarity and reduced overall variability. Evidence from the Department of Health shows that variation in the provision of NHS Continuing Healthcare has reduced significantly across PCTs since 2007. We understand that the Department of Health has been working with strategic health authorities (SHAs) to deliver greater consistency. Steps taken include: improving data collection; greater benchmarking of data; reviewing processes and procedures; improving training and support; and sharing best practice. The reduced variability is likely to be largely due to the introduction of the National Framework and this supporting work.

However, despite this, the Commission is aware that in practice there is still local variation. The Commission, therefore, urges the Department of Health and the NHS to continue with their efforts to improve consistency. There should be further improvements to the evidence base, so that performance can be properly evaluated and monitored. Work must continue to ensure that the Decision Support Tool and Fast Track Tool are applied as consistently as possible across the country, particularly as these processes can appear to be opaque for patients and can lead to disputes and appeals.

Notwithstanding this progress, we believe that there is scope for further improvements in the way that NHS Continuing Healthcare and social care services interact. Where the two services work closely together, and have good working relationships, we expect that there will be fewer disputes and overall outcomes will be better.⁴

The Commission strongly advises the Department of Health to consider explicitly the ways in which NHS Continuing Healthcare and the social care system interact and see if there is room for further improvement. In particular:

• We have proposed that the Government should seek to develop a new more objective assessment process for social care to deliver more

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⁴ There is very little evidence on how NHS Continuing Healthcare works, and this view has been formed by speaking to the Department of Health and professionals working in this area.
consistent practice across England. Given this change, the Department should consider how any new assessment scale for social care would work alongside NHS Continuing Healthcare. In particular, the Government should give consideration as to whether NHS Continuing Healthcare assessment processes could also be improved to achieve similar outcomes.

• We think that local authorities and health authorities need to work more closely together in this area. Ideally, there should be closer commissioning arrangements, especially for those who move between social care and NHS care. We know that individuals are often assessed for NHS Continuing Care, fail the eligibility criteria, and then have to go through another detailed assessment for social care. This can lead to considerable distress for individuals and families, and is time-consuming for professionals.

• We have also recommended that the Government gives consideration to whether it is appropriate to apply a personal contribution to living costs to all people in a care home in the future, regardless of whether their care is funded through NHS Continuing Healthcare, NHS-funded nursing care or through the social care system. This would better align the three funding streams. The Commission believes it would seem unfair if those who enter residential care through the social care system or are in receipt of NHS-funded nursing care would have to make a contribution to living costs, while those who enter through the NHS Continuing Healthcare route would not. Furthermore, in the future we believe the definition of care setting could become increasingly blurred. For example, there is a question over whether NHS Continuing Healthcare should pay for people’s accommodation costs if they are living in extra care housing. The Government would need to give consideration to how such a charge could be implemented and its impact.

• The Commission supports the Law Commission’s recommendation that the quantity and quality test, which is used to determine which health services a local authority can lawfully provide, is put on the face of the statute. Doing so should help to legally clarify the boundary between who provides services. We also support the Law Commission’s recommendation to establish in regulations an eligibility framework for the provision of NHS Continuing Healthcare and to specify the combination of needs which establish a primary health need. Again, this should further clarify the roles and responsibilities of the NHS in relation to social care services.
Re-ablement

Re-ablement packages are aimed at helping people to regain some of the skills and confidence that they may have lost through poor health, a disability or going into hospital or residential care. It is a support package which helps people to learn, or re-learn, and practise skills for daily living, such as washing and dressing, so that they can live independently for much longer.

Funding for re-ablement is a good example of where a more strategic and integrated approach to funding between the NHS and social care can better support people and deliver efficiencies.

The Commission welcomes the Department of Health’s move to fund free re-ablement services for the first six weeks\(^5\) and recommends that this continues in the future. Investing in re-ablement has the potential to improve people’s outcomes – supporting their independence, reducing unnecessary hospital admissions and easing discharges – which will benefit both the NHS and social care services.

Re-ablement services help people to regain their independence after a crisis, and can have a significant positive impact on people’s quality of life. A study on the impacts of re-ablement, from the Personal Social Services Research Unit and the University of York, showed that those going through a re-ablement programme experienced a significant improvement in health-related quality of life compared to a comparison group. In addition, the report suggests that re-ablement is cost effective for local authorities. For the 10 months after a re-ablement programme, people’s care costs were found to be around 60% lower than those who had not gone through the programme – which significantly outweighed the initial costs of providing the reablement service.\(^6\)

End-of-life care

For those approaching the end of life, it is even more important that services work well together, and that funding does not get in the way of meeting the needs of the individuals.

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\(^5\) The Government has committed to free re-ablement for people for the first six weeks, after this point local authorities will be able to raise charges. See: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_122167.pdf

We support the direction of travel outlined by the Palliative Care Funding Review. Ideally, we want to see integrated palliative care services across health and social care which are well co-ordinated and responsive. Packages should be based on people’s needs rather than on their condition or age.

In terms of funding, we believe that there is a strong case for end-of-life care to be free at the point of need, however and wherever it is delivered. At such a time, the last thing that individuals and families need is arguments over who funds care and where care is provided.

**Joining up service delivery**

NHS and social care services often support the same person. Older people often require both health and social care interventions – accounting for 60% of hospital admissions, 65% of bed days and 70% of emergency re-admissions. However, services often do not work effectively together. In comparison, those with learning disabilities and mental health conditions, who can also be heavily reliant on both services, often experience services which are far more successfully integrated than those for older people. Across the country we see many benefiting from joint packages, facilitated by joint commissioning arrangements and pooled budgets.

We believe that it makes much more sense to think strategically about how services are commissioned and resources are deployed. For example, better care management of people with dementia, focusing on earlier diagnosis, could be beneficial to both the NHS and social care. When services work well together, we see better outcomes for individuals, improved experiences for those using services and more effective targeting of resources. When they work poorly together, we see disputes, professional distrust and inefficiency.

The Commission welcomes the Government’s vision for greater integration of health and social care, and believes that the commitment to closer working between the two areas in the latest Spending Review is a positive step forward. We urge the Government to consider further steps to align services.

The Law Commission has recommended that a new social care statute would establish a duty on each social services authority to make arrangements to promote co-operation with specified bodies, including other authorities and the NHS. We strongly support this move. Evidence

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7 For more information on the review, see: [http://palliativecarefunding.org.uk/](http://palliativecarefunding.org.uk/).

8 The Department of Health has brought together examples of how to support local delivery of the national dementia strategy and improve outcomes for people with dementia and their carers. See: *Living Well with Dementia: a National Dementia Strategy. Good Practice Compendium – an assets approach*, Department of Health, 2011.
from front-line professionals indicates that disputes between local authorities and the NHS can take up significant amounts of time, and lead to great distress for individuals and their families.

**Delivering joined-up services**
Local authorities and the NHS currently have the power to pool budgets and integrate health and care services. Different localities have gone about integration in different ways. Some have chosen full structural integration, others have pooled budgets and some have jointly funded services, such as crisis response. There are examples of good practice across the country.

It is not within the scope of this Commission to provide detailed recommendations on how integration is best implemented – we know what works is highly dependent on local factors and professional relationships. The Government is also setting out its own policy direction in this area. What we can do, though, is offer our observations on the factors which we think can help to deliver more coherent services.

**Local planning**
Local areas are already producing Joint Strategic Needs Assessments (JSNAs) in order to better understand the needs of their local populations. In the future, we would encourage local areas to build on these assessments to jointly commission and deliver services. Local areas should take a broad view of the determinants of health and well-being, and consider the roles of housing, education and leisure in addition to health and social care.

**Pooled budgets**
The Commission does believe that while there are multiple budget holders, joined-up services will struggle to work effectively, as disputes could always arise. The Commission is strongly in favour of pooled budgets and encourages the Government to do all in its power to promote their use.

**Joined-up assessments and multidisciplinary working**
The Commission understands that different professionals support people in various ways, and that it may be necessary for a number of people to carry out assessments to ensure that all aspects of a person’s needs are taken into account. However, in the future, we think that people should be able to expect information to be shared between professionals; practitioners should be more widely trained to do simple, basic assessments to avoid unnecessary duplication.

Better communication between professionals, single points of contact and increased multidisciplinary working has the potential to deliver a higher quality service to individuals and carers. For example, it could
avoid people having to repeat information, reduce assessments and visits, and facilitate more joined-up care plans.

We think that there is a real case for improving the assessment process through better alignment of carers’ assessments with the individuals’ assessment. At the moment, carers can be assessed a long time after the individual and we know that for many it can seem to be quite meaningless. In the future, we believe that there should be a more joined-up approach where assessments are done separately, but they happen at around the same time. It is important that such assessments take full account of the family circumstances and the needs of the carer and cared-for. The role of carers must be taken into account in a proportionate manner in defining the overall care plan.

We also support the Law Commission’s recommendations that the new social care statute would set out a single and stand-alone duty to undertake a carer’s assessment and that once this has been undertaken, the local authority would need to decide whether to provide services to the carer based on an eligibility framework for carers’ services. Under this proposal, local authorities would be required to meet the eligible needs of carers, either by providing services to the cared-for person or to the carer. We discuss changes to the carer assessments further in Section 2.1 of this report.

**Personal budgets**

The Commission supports the Government’s commitment to personal budgets and direct payments for adult social care. These offer people greater control of their care, making sure that services support them in the way that they want. Building on this, we support the principle of personal health budgets for those with long-term conditions. In time, we expect that these budgets could be combined with social care budgets to facilitate more holistic care planning, shaped around the individual.

**Social care and benefits**

In Section 2.1 of the report, we explained how disability benefits will continue to support people with a care and support need.

For older people, there will continue to be a non means-tested disability benefit (Attendance Allowance). AA supports people faced with additional costs due to having a care and support need, and can support early intervention. However, we suggest that the Government considers how to better align AA with the reformed social care system, and clarifies its role through re-branding.

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9 Personal health budgets are currently being piloted by the Government, and a full evaluation has still to be completed.
For working-age adults, the Government has also signalled the reform of Disability Living Allowance (DLA) and the introduction of the Personal Independence Payment (PIP). Eligibility for PIP is based on a face-to-face assessment. Given these changes, the Commission does not propose further amendments to working-age disability benefits, but the Government will need to consider the interaction of PIP with the new social care funding system and whether further changes are required.

**Joined-up assessment processes**

There is potential for a more joined-up assessment scale between disability benefits and the adult social care system in the future. Better alignment would mean that people experience a simpler and more streamlined process. We recommend that, as the assessment system for social care is changed in future, the scope for greater alignment between the assessments for disability benefits and social care is considered at this point.

Alongside AA and DLA, there are other benefits, grants and funds that people may be eligible for, depending on their circumstances. Examples include Carers’ Allowance, Severe Disability Premium in Pension Credit, Disabled Facilities Grant (DFG), and Supporting People. Interactions between these different benefits are complex, and the Commission recommends that the Government considers undertaking a full review of the effects of changes to the funding of the social care system on these benefits. Where possible, the Commission urges that the Government considers how to simplify and streamline the system, aligning funding streams around outcomes and adding clarity on the purpose of each.

Further work and consultation would be necessary with devolved administrations because universal disability benefits are reserved matters, whereas social care funding is a devolved matter.

**Social care and housing support**

The Commission understands the critical role that housing provision plays in improving well-being and delivering better outcomes for individuals. Providing people’s care and support in the most appropriate and cost-effective way must be a priority for the future.

Being housed in suitable accommodation can improve someone’s overall quality of life and well-being by offering greater security, support and peace of mind. Specific support through aids, adaptations and home modifications can also help people to remain at home and manage needs. They can also often prevent needs escalating.
The Commission believes that just as with health services, housing and social care services should work better together. Health, housing and social care needs should ideally all be assessed and delivered jointly, so that individuals receive the optimum level of care. The Commission would like to see closer integration of housing and social care services and budgets, and better alignment of assessment processes. The local JSNA could be one mechanism for achieving this.

**Accommodation**

The Commission has been clear that its proposed reforms should not favour any particular residential setting. The care setting should be the choice of the individual, while being appropriate for their needs.

We know that many people are attached to their family home, and our proposals help people to stay in their homes for as long as they wish. However, evidence suggests that some people remain in their homes when it is no longer appropriate to do so, given the level of their care needs. If people were aware of their options, they might find that downsizing or moving to a more suitable type of accommodation could be highly beneficial to their health and well-being. Evidence from the Joseph Rowntree Foundation\(^\text{10}\) suggests that people need to consider moving home when they retire, because older people become more reluctant to leave their home and face the upheaval. Given this, the Commission would like to see people being able to access more information about their housing options so that they can better plan and prepare.

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\(^{10}\) For further detail, see: *Viewpoint on Downsizing*, Housing Learning and Improvement Network; Viewpoint no. 17, Sutherland J, 2010, www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Viewpoints/Viewpoint17_Downsizing.pdf.
Extra Care Housing

Extra Care Housing describes a type of specialised housing that provides independence and choice to adults with varying care needs and enables them to remain in their own home. Extra Care Housing should be able to provide most residents, if they so desire, with a home for the remainder of their life, regardless of changes in their care needs.

Services are provided in a purpose-built housing environment with care and support delivered to meet the individual resident’s needs. This type of housing provides 24-hour support, meals, domestic help, leisure and recreation facilities and a genuinely safe environment to its residents.

It can provide a base for out-of-hours or outreach services to the local community. Intermediate care facilities, to prevent avoidable admission to hospital or to help people return from hospital to their own home more quickly, can also be based at Extra Care Housing schemes.

The Commission has been impressed by the benefits of Extra Care Housing. Many of these schemes have proved to be very successful in keeping people independent and active. There is also an indication that they help people to avoid moving into more intensive residential care settings. The problem is that the supply is currently very limited, waiting times are long (they can be up to four years), and the provision is expensive. The Commission believes that the capped cost scheme should help to facilitate more of this type of activity and would like to see more schemes of this nature being developed.

Aids and adaptations

Assisted living is one of the most promising developments for ensuring that people continue to be well served with high-quality and affordable health and care services.

Simple aids and adaptations can have a huge impact on someone’s life. The positive effect on an individual’s well-being of a grab rail, raised toilet seat or kettle sling should not be underestimated. It often costs very little, but can deliver improved outcomes for people and prevent their needs from escalating.
At the moment, we believe that there are people who could benefit from aids and adaptations but are not doing so.\textsuperscript{11} There is only limited public funding for aids and adaptations and there appears to be reluctance from those funding their care alone to invest in adaptations.

The Commission also believes that it would be prudent for the Government to review the funding and operation of the DFG as it takes forward its programme of reform. We are concerned about the length of time it currently can take for people to access funding for fairly small, routine adaptations under the DFG. We understand that this can be around two years, and for some people it can be much longer.\textsuperscript{12} We also think that the current system is overly burdensome, with significant administration costs. Moreover, the funding is not integrated with social care budgets, although both aim to help support those with a care and support need to stay safely in their own home. Separate administration of these funds is not conducive to delivering coherent support for people in need of care.

### Technology

New technology opens up new possibilities for care and support. From simple devices, such as a medicine alarm, to more sophisticated telecare systems, technology can help people to stay in their own homes and live independently for longer. Telehealth can also help people in managing long-term health conditions, through the monitoring of vital signs of people with illnesses such as coronary obstructive pulmonary disease (COPD) or diabetes.\textsuperscript{13}

The Commission is aware of promising developments in this area, with some local authorities evidencing significant savings from the roll-out of services across their populations. For example, we understand that North Yorkshire Council has embedded telecare services into its social care provision, saving around £1 million p.a. as a result.\textsuperscript{14}

The Government has signalled its support for telecare, and the Commission supports this direction of travel. In the future, the Commission would like everyone who could benefit from technological support to be able to access information and be able to buy appropriate

\textsuperscript{11} For example, the \textit{Time to Adapt} report by the charity Care and Repair suggests that there is a major shortage of funding for adaptations and repair. Evidence from \textit{Adapting for a Lifetime} by Foundations (the national body for home improvement agencies) also highlights the importance of adaptations and the shortage of funding.

\textsuperscript{12} Evidence from a Freedom of Information request from the \textit{Daily Telegraph}, 2010.

\textsuperscript{13} For more information about telecare and telehealth see: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_100947.pdf.

\textsuperscript{14} See: www.csed.dh.gov.uk/AT/.
products. We believe that many of those currently funding their own care and carers may not be aware of this type of support, or where they can access it.

**Incentivising early action**

Throughout our work, we have heard from professionals and carers that a greater focus on prevention and early intervention would be highly beneficial. Many have said that, under the current system, limited resources need to be focused on those with the higher-level needs, to the detriment of prevention and early intervention.

We believe that our funding reforms should encourage people to intervene earlier and to invest in preventative activities. If people are able to plan and prepare better for the future costs that they face, and if they know that there is an overall limit on what they will need to spend, we believe that this should encourage greater investment at an earlier stage in their care journey. In effect, people will not need to be as worried about keeping all their assets in reserve in case their needs worsen to a level where they face many years of very high expenditure.

We have also recommended that universal disability benefits continue in the future. These cash benefits support people in paying for services that can help to keep them healthy and well.

The Government has demonstrated strong support for prevention and we know that local government is also strongly in favour of more resources being dedicated to early intervention. In the future, NICE may want to consider evaluating different interventions to assist professionals in designing preventative services that offer value for money.

The Commission also expects that local areas will put in place strategies for prevention and early intervention as part of their JSNAs and health and well-being strategies. In the future, we expect local areas will have specific public health responsibilities, and we expect that local authorities will support interventions aimed at those of working-age with a care and support need, older people, and carers. We would also encourage local bodies to work collaboratively in developing joint strategies and commissioning arrangements in this area.

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15 Subject to the current Health and Social Care Bill.
The financial services sector

We think that there is also significant potential for the financial services industry to use its expertise in risk management in order to help stimulate better planning, early intervention and prevention activities. Providers of financial services can also offer further information and advice to people on how to stay independent for longer.

It may be that financial products emerge which support people when they first develop a care need (e.g. at lower eligibility levels than the state system) and then cover people up to when the state takes over. With such products, providers have a real incentive to manage the risks and prevent someone’s needs escalating, in order to reduce their overall costs. The state would also benefit here, as fewer people may enter the system, or enter at a later stage.

Supporting the well-being of carers

The contribution of carers complements that of formal care services and is of great value to those who they care for – so there needs to be a care and support system which actively engages with, and supports, carers. We believe that carers should be able to have a life of their own alongside their caring role, including entering or returning to paid or unpaid work, education, training and leisure activities. An improved carer’s assessment will be key to achieving this.

In particular, we want any reformed adult social care system to enable carers to undertake paid and unpaid work, should they want to. We encourage the Government to push forward with efforts to encourage and support carers to work, as carers make a valuable contribution to the economy. We also believe that it is in an employer’s interest to be flexible when considering the needs of someone with caring roles. Better provision of information and advice could play a valuable role here. For example, many carers may be unaware of their legal right to request flexible working arrangements.16

Improving the quality of care

It is our expectation that our reforms are an important step in delivering higher-quality services overall. We believe our proposals should lead to a better-resourced system, where people are not fearful of the future and feel able to spend their money more effectively and manage their care more proactively.

During the course of our work, many people have raised issues about the delivery and quality of care provision. For example, there are complex issues around workforce, the residential care home sector

16 Evidence from the Standing Commission on Carers to the Commission, June 2011.
and regulation. It is not within our remit to explore these issues in
detail, as the Commission’s task is to advise on the funding of care, not
the provision of care. The Government has already outlined its policy
direction in its vision for adult social care\textsuperscript{17} and through the work on
developing a quality framework for social care.\textsuperscript{18}

We are strongly supportive of the Law Commission’s proposal to place a
duty on local authorities to stimulate and shape the market for services.
If people are to have choice and control over their care, and be able to
design truly personalised packages, it is going to be necessary for people
to be able to purchase a range of high-quality services.

We urge the Government to consider how the whole care and support
system can be reformed to deliver better-quality services and improved
choice in its forthcoming White Paper.

\textsuperscript{17} A Vision for Adult Social Care: Capable communities and active citizens, Department of

\textsuperscript{18} Transparency in Outcomes: A framework for quality in adult social care, Department of
Health, 2011.
3.2 Planning and preparing

Summary

Planning and preparing

• Our reforms will help people to plan for their future care needs by making clear what an individual will need to contribute, and by proposing a clear, national offer. **To build on our reforms, we recommend that the Government runs a major awareness campaign on the cost of care and support and the new funding system.**

Information and advice

• To support our proposals, the Commission strongly recommends that the Government develops a new information and advice strategy, co-produced with the sector, which both provides trustworthy basic information and signposts people to further advice.

• The Commission recommends that the Government sets up a new national information service (including a new website) to explain how the care and support system works, and which also links to other trusted sources of advice. We believe that basic information on the system – applicable to everyone – is best provided at the national level.

• Local authorities must take responsibility for providing better information and advice to their local populations, especially those funding the care themselves. In particular, individuals, families and carers should be able to access expert and trustworthy advice which relates directly to their circumstances and helps to build the optimum care package. **We strongly support the Law Commission’s proposals that a new social care statute should place duties on local authorities to provide information, advice and assistance services in their area and to stimulate and shape the market for services.**

• **We recommend that the Government should work in collaboration with the Financial Services Authority and other partners to develop greater support for those seeking information on financial planning for older age.** This should cover both information for all (e.g. through schemes such as the Money Advice Service) and bespoke independent advice delivered through financial advisors.
**Introduction**

Evidence from our research and from stakeholders confirms that there is currently a very poor level understanding of how the adult social care system works – many people are living under the false impression that social care is free at the point of use and, understandably, they have difficulty distinguishing between health and social services.

If people are confused about how the system works and the costs that they potentially face, they cannot plan or save appropriately for the future. Not preparing can lead to families feeling they have not made the best decisions at what is often a distressing time, or feeling regret at not acting differently earlier. For our funding reforms of the system to be successful, we need to encourage people to consider what they want from later life and what steps they need to take in order to achieve this.

Part of tackling this problem is provision of better information and advice. Everyone needs to be able to access information about how the system works, what support they are eligible for from the state, and the public and private services that are available. The importance of improving the information available cannot be underestimated – and must be a core part of any programme of reform.

Information and advice is also critical for those who may be unable to plan and prepare for their care needs. We understand that those who are born with a disability or who develop a care and support need early during their working life will not be able to prepare for that eventuality. However, they do still need access to good advice and information which helps them to decide how best to meet their care needs.

In this section of the report, we firstly analyse some of the broad issues around encouraging people to plan for the future. We then go on to discuss how to improve the information and advice available to everyone, on both the funding and provision of care.

**Planning for the future**

Today, we face two key problems. Firstly, most people do not understand how the current system works. Secondly, if people do understand or are at least aware of the issues, there are no real steps that they can take to protect themselves from the risks that they face. These two problems combine, with the result that as a society we do not want to think about the current system until it is too late.

Our research with the public and evidence from stakeholders indicate very strongly that people are reluctant to think and take action about planning for the costs and risks of having a care and support need.
Evidence suggests that this is due to a range of factors, including the following:

- **People do not think that they need to prepare** – many do not understand the current system\(^1\) and there are widely held misconceptions over the role of the state, with many thinking that social care is free or is part of the NHS.

- **People do not want to think about the issue** – a future care and support need can appear a very remote prospect and saving in advance for it can be afforded a lower priority.\(^2\) We know that people have a general reluctance to think about something which they perceive as unpleasant. Evidence also suggests that people often do not have the capacity to consider planning for something that is a long way into the future – behavioural economists\(^3\) believe that people prefer focusing on short-term, rather than longer-term, benefits.

- **People have different attitudes towards, and understanding of, risk** – some people are willing to take a risk, and do not see the necessity of planning, while others would prefer to be covered against all eventualities. We also know that there is poor understanding of the risks in this area. For example, during our research with the public, many people had little idea of the cost of a residential care home for a year.

- **People are not able to take action, should they wish to** – even if people want to plan, under the current system, there is not very much that someone can do. The only way of protecting oneself against future care costs is general saving. However, people have competing priorities, particularly those on low incomes, which mean that saving and income also need to support other expenditure, such as supporting children, paying off debts, home improvements and holidays.

### Financial planning

The Commission strongly believes that our current system does not support planning. Indeed, its complexity and the lack of any financial protection could be said to discourage people from addressing the issue. There are aspects which, as a Commission, we can specifically address in our recommendations – and we outline some of these in the next

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1 According to Ipsos MORI research carried out for the Department of Health in 2010, 57% of people know either nothing or not very much about the care and support system.

2 *Public engagement exploring care and support funding options*, TNS-BMRB on behalf of the Commission on Funding of Care and Support, 2011.

section. Our work relating to the reform of the funding system will also help to tackle some of the problems around incentives to save, which we believe arise in the current system.

In addition to changes to the social care system, we also believe that there are wider barriers to saving that need to be tackled at a societal level. We know that the Government and financial services industry are already trying to get more people to save into pensions; we see saving into a pension and saving to cover social care in later life as being closely linked, since both are preparing for older age.

Those working in the area of retirement savings have concluded that there are three key areas which are important in encouraging people to save for the future. These are:

• a more stable environment – constantly changing systems and uncertainty in the policy landscape mean that people are less willing to engage in saving for their future;

• greater trust in financial products and advice; and

• encouragement to start saving for the future, for example through simplified products or auto-enrolment mechanisms.

We are aware of the wider work in progress across government on these areas. Examples include the Retail Distribution Review, intended to improve the quality of financial advice, and the newly formed Money Advice Service, which aims to help people to manage their finances by providing free, unbiased information. The formation of the National Employment Savings Trust (NEST) is an example of defaulting people into a product in order to encourage saving.

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4 The FSA carried out a large-scale survey into the financial capability of the UK population. The results, published in 2006, indicated that large numbers of people, from all sections of society, are not taking basic steps to plan ahead, such as saving sufficiently for their retirement. See: www.fsa.gov.uk/pubs/other/fincap_baseline.pdf.

5 For example, see: An Age-old Problem: Developing solutions for funding retirement, Chartered Insurance Institute, 2011.

6 See the following link on the FSA website for further detail on the Retail Distribution Review: www.fsa.gov.uk/pages/About/What/rdr/index.shtml.

7 See the following link for more information on the Money Advice Service: www.moneyadviceservice.org.uk/about/default.aspx.

8 For more information on NEST, see: www.nestpensions.org.uk.
We believe that the Government should widen its efforts in encouraging people to save for retirement to include saving for social care costs. It does not necessarily make sense for people to save for their social care needs in isolation – saving flexibly for later life is sensible. However, it is important that people are encouraged to think about all the costs that they may face in retirement.

**Wider planning**

Encouraging financial planning is only one aspect of helping people to be prepared. The Commission believes that individuals and families should also be thinking more about where they live, how they expect to support one another in later life and what steps they can take to live an active, healthy and fulfilling retirement.

In Section 3.1 (on the wider care and support system), we address the role of housing in supporting people with a care and support need. We discuss how moving to more suitable accommodation and downsizing earlier in retirement can improve overall well-being. People are attached to their family homes and it is understandable that there is a reluctance to leave. However, moving becomes more difficult as someone ages – and people can be forced to leave because they are no longer able to cope or it is not safe for them to continue to live in their home. Early planning can therefore be highly beneficial – it increases choice, putting people in control of making the decision that is best for them. It can facilitate moves into a different type of accommodation (such as Extra Care Housing) or to a more suitable property (e.g. one with a downstairs bathroom, a property on one level or one with a lift).

We know that many people would ideally want to care for their family members. However, when we talk to people about how they plan to deal with developing a care and support need, they often say that they do not want to rely on families or ‘be a burden’. Results from our deliberative programme of research indicate that although some people want to be cared for by their family, many thought that this was not always realistic or fair. Having said this, for those from certain ethnic groups with a strong culture of caring, this was felt to be the main way of supporting people. We believe that thinking about these issues early, before any need has arisen, can help families to make more informed decisions and take any necessary actions.

Finally, we think that people could benefit from thinking more generally about getting older and the steps that they could take to stay active, healthy and well. When people retire, they can now look forward to many years of being active and fit. Taking up new activities can help people to forge new social relationships – combating loneliness and social isolation. It can also help to maintain mental and physical fitness.
and well-being. In the future, we want people to be more aware of the options open to them and be able to take steps to actively plan for the way that they live their later life. The Government should continue its efforts in this area and ensure that the different strands of government link effectively.

**Supporting people to plan and prepare**

**A clear contribution from the individual**

Part of our rationale for proposing a capped cost scheme is that it should encourage and support people in planning. By giving them a clear indication of the maximum costs that they will need to cover, should they develop a care and support need, individuals and families can take the steps necessary to ensure that their contribution can be met.

Our research with the public has shown that ‘having a target’ to plan for is reassuring, and was one of the key reasons why people supported a funding approach which capped their overall costs. \(^9\) Currently, those funding their own care have no idea how much they might have to spend if they developed a care and support need.

**A national offer**

Having a clear national offer will also help people to plan. Under our proposals, everyone assessed as being eligible would have to make the same contribution (unless they qualified for support under the means-tested system). Eligibility would be set nationally, with assessments being consistent and portable. People would know that, wherever they live, they are entitled to support on the same basis and can then plan accordingly.

Responses to our Call for Evidence, including from the financial services sector, also asked for a clear statement from the Government on the state offer, and for there to be some certainty that any settlement will last in the longer term. While acknowledging that any system which lasts for a long time will need to be able to flex and be resilient to change, we agree that it is essential for people to have some degree of certainty over the shape of the future system.

**An awareness-raising campaign**

To support the new system, the Commission believes that it is absolutely essential for government to communicate the new offer effectively and highlight the need for people to plan and prepare for older age.

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\(^9\) *Public engagement exploring care and support funding options*, TNS-BMRB on behalf of the Commission on Funding of Care and Support, 2011.
We believe that an effective campaign should:

- **make people aware of the costs that they potentially face in paying for care** – currently there is very low understanding of the chances of needing care, and the costs to which people are exposed. We believe that any campaign needs to inform people of the risks and costs and put these into context; and

- **reframe social care within the broader context of preparing for later life** – social care currently has low salience with the general public and asking people to think about social care costs alone has proven to be ineffective. We believe that there is potential to reframe the issue, and ask people to consider the lifestyle they want in the future, and the costs associated with having a care and support need. By linking the need to plan for care costs with those of pensions, we believe that there is the potential to encourage more people to plan financially for the future.

It is not within the Commission’s remit to design such an awareness-raising campaign in detail, but we recommend that the Government builds on the significant body of research on behavioural change – from both the public and private sector. Extensive research on behavioural change has already been conducted by government and this should offer lessons on how to develop effective interventions in this area.10

**Better information provision for those with a care need**

The current poor provision of information and advice has been raised consistently with the Commission in its gathering of evidence. There are examples of some good practice, but on the whole our evidence strongly suggests that people are bewildered by the system and do not know where to go or who to talk to for advice on their personal circumstances. Better information and advice will support people in planning and preparing, but also has the potential to improve the outcomes for individuals and families already receiving care and support.

Information and advice needs to be available to everyone, of any age. It needs to support those who are thinking about the future, those who are caring and those who are currently using services. It needs to cover both the provision of care services and financial support. It needs to come from trustworthy sources.

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10 An example of such work is that by the Cabinet Office into MINDSPACE.
Information for those thinking ahead

For those who are seeking to plan for the future, there needs to be better access to information. At an absolute minimum, there must be a single national website that explains how the care and support system works and signposts people to sources of more personal advice.

At a national level, there needs to be a central depository of information on the care and support system – marshalling together all the relevant basic information that is applicable to all. It must be user-friendly and support those needing care and support, as well as their families and carers.

All this information would need to be kept up to date and the system properly resourced. People will need to be reassured that the information which they are accessing is reliable and can be trusted.

There is a need to assign a lead government department to bring together all the information in one place. Information needs to be clearly structured and include areas on the financial support and services available. There must also be an explanation of the different systems (e.g. NHS Continuing Healthcare, social care, disability benefits, support for carers and housing support) and of the eligibility criteria for each.

In addition, the website needs to direct people effectively to additional information – for example to their local authorities, to other parts of government and to financial information. It should also provide signposts to advice – both to local authorities and third-sector organisations.

People need more help with obtaining sound information and advice at salient points in their lives – such as when they consider their financial position at retirement or have a health check with their GP.

Financial information and advice

Government departments need to work in collaboration with the FSA and the new Money Advice Service to develop greater support for those seeking information on financial planning for older age. The Money Advice Service already has information on planning for retirement and long-term care costs; we recommend that this information is enhanced and effectively signposted from other sources (such as local authorities and central government). People should also be made aware that tailored independent financial advice could be appropriate.

Through our Call for Evidence, a lack of appropriate financial advice was highlighted as a key barrier to the development of financial products to support those with a care and support need. Some organisations have also raised the fact that very few people who sell their home to pay for
care receive proper independent financial advice. It is claimed that, under our current system, many could avoid losing their housing assets if they accessed advice when moving into residential care. The Joseph Rowntree Foundation has also undertaken a study on the use of equity release, in collaboration with a number of local authorities and other third-sector organisations. The preliminary indications are that those on lower incomes could achieve better outcomes if they were able to access financial advice.\textsuperscript{11}

Those responding to our Call for Evidence raised the issue of many independent financial advisors not being qualified or not choosing to sell long-term care products. We suggest that the FSA considers how to ensure that advice on the financing of care and support costs is part of the financial advice that someone can expect to receive at retirement from an independent financial advisor (IFA). As people become more aware of the full costs that they face, they will need to understand the different mechanisms and approaches that they can use to manage these costs.

We have also recommended that the Government set up a working group to consider how best to support the development of financial products (see Section 3.3 on the role of financial services). As part of its work, the group should examine issues around the sale and distribution of products, including the appropriate qualifications of IFAs, distribution channels and how to ensure that necessary safeguards are in place.

**Advice for those receiving care and support, and for their carers**

To have real choice and control over their care packages, people need information. We know that a lack of information and advice is a real concern to people and is a significant barrier to personalisation.

In particular, we believe self-funders are often poorly served in this regard.\textsuperscript{12} Those receiving support from the local authority through the means-tested system will have some contact with professionals who may be able to provide advice. Those individuals and families without this specific contact can be unaware of the support that they could access. For example, many may benefit from wider support offered by the local authority or community based voluntary organisations.

In the future, we are recommending that information and advice should be a universal service offered by all local authorities that is available

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to all, including those fully funding their own care. It is the role of local authorities to make provision, so that everyone within their local community can get the information and advice that they need. Given this, we strongly support the Law Commission’s proposals that a new social care statute should place duties on local authorities to provide information, advice and assistance services in their area and to stimulate and shape the market for services.

In providing a universal information and advice service, we believe that local authorities should:

- ensure that there is good-quality, up-to-date information available for their local populations;
- provide specific advice and support relating to an individual’s personal circumstances;
- offer specific support to carers, including signposting to third-sector support where appropriate;
- work with trustworthy local voluntary, community-based organisations to provide support and advocacy services;
- work with GPs, so that they can play a far more active role in directing people to local sources of information, advice and support, when appropriate; and
- work with local community services and providers to make sure that people are able to access information on, and purchase, the services that they want. Local authorities will continue to have a role in shaping the local market, and this must include ensuring that people are aware of the services on offer.

Information and advice provided by local authorities will need to be consistent between different areas insofar as it relates to matters of national policy. Central government should consider whether it should set out national standards and guidelines that relate to this advice.

Advocacy services also need to form an important part of any information and advice strategy. Local authorities should ensure that people are offered support in this area, should it be necessary. Advocacy can range from those who need some support in expressing themselves and speaking up (and which can be provided by local volunteers) to formal, paid advocacy from the Independent Mental Capacity Advocacy

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13 Adult Social Care, Law Commission, 2011.
Service. The Law Commission has recommended that the existing right to advocacy is maintained within any reformed statute.

Support for carers
Having spoken to a number of carers and representative organisations through the course of our work, it has become clear that better information and advice for carers is urgently needed. As with more general information and advice, this needs to be at a local and national level.

In particular, many carers have said that they struggle to find information on the financial support available – and there is a risk that people make the wrong decisions because they have not been able to access appropriate advice. There also appears to be a lack of information on formal support services. Carer organisations have told us that many carers are willing to pay for quality services if it allows them to participate in work. There is a link here to the need for a more vibrant and high-quality market for care services.

Conclusion: An improved information and advice service
In summary, the Commission strongly recommends that the Government looks at how to deliver a much improved information and advice service – for individuals and carers, on both delivery and funding of care.

National information for all
The Commission believes that there needs to be better provision of basic, factual information at the national level – and that this is probably best done through a new website. This needs to cover a range of issues, including:

• how the overall care and support system works – the different components, and eligibility for each;

• signposts to more specific advice, tailored to an individual’s need, at the local level;

• support for carers and sources of advice;

• financial information and signposts to where further advice can be found – particular for the means-tested component of the adult social care system; and

• information on the different types of services that people can purchase, such as telecare or support from a care assistant.

This information would need to be regularly revised to ensure its continued relevance.
Local advice for the individual
At the local level, local authorities should take responsibility for providing specific advice tailored to individuals – and this should be a universal service. Advice is required for both those funding their own care and those within the means-tested system on how the system works and on how to put together their care package.

Linked to this, the Law Commission has also said that local authorities should have a duty to stimulate and shape the market for services. The success of personalisation will be dependent on both the quality of this advice and the availability of a viable market for social care services.

We also recognise the role played by different voluntary groups – whether physical or virtual, formal or informal – in supporting individuals and carers. It is not government’s role to provide this type of support, nor would it be advisable for it to do so. However, people should be directed to such support, if appropriate.

A co-produced strategy
It is not within our scope to design an information and advice strategy. However, there are some general principles that we believe the Government should adhere to when considering how to take our recommendations forward:

• Information on the overall system must be accessible. A central information site, like NHS Choices, should be available and well-publicised, so that people can access basic information about the care and support system. The Government needs to assign responsibility to bring all the relevant information together. Information sources must effectively link together if people are to experience more joined-up services. For example, people searching for information on disability benefits should also be able to access information on the social care system.

• The information and advice that people receive needs to be of a high quality, consistent and trustworthy. Partners should work together to ensure that the guidance provided is clear, coherent and informative.

• Professionals need to: seek to improve their understanding of the different types of support available; know about different types of information sources; and effectively signpost people. In particular, we think that GPs could play an important role in this area, as they are in close contact with many of those who could benefit from more information and specific advice.
Different groups will bring different experience, perspective and expertise and help to ensure that all people’s information and advice needs are covered. It should also help ensure that information is designed around users.
3.3 The role of financial services

Summary

• The **Government should set up a working group** of central government, local government, the financial services industry, the Financial Services Authority (FSA) and interested third-sector organisations in order to consider how to a) enable the development of an effective market and b) support consumers in making sound choices.

• **HMRC should clarify the tax treatment of disability linked annuities to further encourage activity in this space and we recommend that the Government makes a clear statement that disability linked annuities are permissible under current pension taxation rules.**

• In order to support the industry in managing the risk and pricing products, there should be **more systematic data collection on risks of developing care needs and duration of those needs**. We suggest the Government should develop any new studies in collaboration with the sector.

Introduction

Our proposed changes to the adult social care system create a new space for financial products. By capping the overall risk and encouraging people to plan, the opportunity arises for a range of new products to develop, suiting different wealth, income and age groups. The development of new financial products will help people to prepare for the future. Financial products can help to support people in managing their money over the course of their lifetime and plan for the costs that they may face.

The current market for long-term care insurance

No major insurer is currently offering pre-funded long-term care products in the UK. The only significant tailored long-term care product available in the UK currently is an immediate-needs annuity, usually purchased by someone moving into residential care. An immediate-needs annuity is not a pre-funded product, but one taken out when someone...
has a care need. A lump sum is paid to the annuity provider, which then pays the cost of care for as long as the person lives.\footnote{Evidence submitted to the Commission from the Association of British Insurers in 2010 states: Immediate Needs Annuities provide cover for those at a crisis point. Purchased by a lump sum, Immediate Needs Annuities are the only product that can ensure the customer will be able to meet their care costs for life. They pay out regular monthly benefits free of tax if paid to a care provider registered with the Care Quality Commission or taxed as a Purchased Life Annuity if paid directly to the care recipient. Benefits can be inflation linked and the premium can be protected in the event of earlier than anticipated death of a care recipient. Each application is assessed to set the price for the individual. The average purchase price of an immediate needs annuity is £80,000 and provides a monthly benefit on average of £1,600.} It is often paid for through the sale of the individual’s home at the time that they move into a residential care setting. There are currently around 1,000 immediate-needs annuity policies taken out each year.\footnote{Care of Elderly People: UK Market Survey 2010/11 (23rd edition), Laing & Buisson, 2011, p. 192.}

Pre-funded care insurance policies were first launched in the early 1990s as pure risk insurance policies. As the market developed, various other alternative payment vehicles were launched, including single premiums and a range of investment-linked options. In the early years, the pre-funded market did start to grow encouragingly, even though the products were expensive and public awareness of the restricted state provision was low. However, from around 1998 onwards there was a rapid decline in sales, until all major providers withdrew. A number of reasons have been put forward, including public uncertainty over the state offer, reputational damage to insurers linked to the difficulty of pricing the product, and investment risk.

**International markets**

There is currently no pre-funded long-term care insurance market, covering all of an individual’s potential care costs, operating anywhere in the world. The two countries with the largest markets for long-term care insurance are the United States and France. However, these markets are still limited to only a relatively small proportion of the overall population. The underlying system of state support and public attitudes towards taking out insurance are also very different to that of England. In the United States, the Organisation for Economic Co-operation and Development (OECD) estimates that about 5% of the population aged over 40 hold a long-term care insurance policy. In France, it is about 15% of over-40s.\footnote{Help Wanted?: Providing and paying for long-term care, Colombo F et al., OECD Health Policy Studies, OECD Publishing, 2011.}
Research by the OECD\(^4\) suggests that two main product types have evolved – reimbursement products and indemnity products.

- Reimbursement products, which dominate in the US, typically provide people with cover up to a certain point, for example the contracts generally specify a maximum amount of benefits payable.

- Indemnity policies, which dominate in France, provide people with a fixed level of monthly benefits for life, once the insuree meets the criteria set in the policy.

Recent market developments have led the OECD to conclude that insurance providers are moving more towards indemnity policies, which provide fixed cash benefits to qualifying individuals, which can then be used according to their preferences. The advantage of this approach is that the policies are flexible and simple for people, and the risks are more manageable for insurers. The disadvantage is that people will only receive a set amount of financial support, which may not meet the full costs of care. An individual’s care costs could be far higher, and hence they are still exposed to potentially very high costs.

**Barriers to the development of the market**

**The industry view**

The Commission received a great deal of evidence from insurance and reinsurance companies, as well as other expert commentators from the financial services sector. We have also reviewed relevant academic research.

The sector has been broadly supportive of the principle of capping the tail-end risk. There is an understanding that the products which may emerge in the space before the cap may not be pure insurance-based solutions – for example, it is more likely that products will pay out a fixed sum, rather than insuring someone against the full cost.

The sector thinks that some people may choose to self-insure – and that this would be a sensible and rational response. However, they believe that new opportunities could emerge in the areas of pensions, convertible life and critical illness policies, mortgages and savings. Top-up products could also develop.

\(^4\) Ibid.
Response to the Call for Evidence

In the response to the Call for Evidence, the industry argued that the development of new financial products could support people in meeting their own contribution. The key benefit of insurance was viewed to be risk pooling, because it would lead to a reduction in the overall cost that an individual was liable to pay, and thus benefit all. In addition, improved choice, the ability to save and plan more effectively, increased peace of mind, improved quality of services, protection of assets and more preventative activity were all seen as key advantages to financial products.

The industry cited its concern over both demand and supply barriers (see below), which had led to a failure to risk pool on any significant level. As a consequence, some favoured compulsory insurance or at least auto-enrolment/‘nudge’ mechanisms. Other enablers were noted, including the advantages of a national eligibility and assessment framework, an improved regulatory regime and tax incentives. A number also mentioned that government could play a role in helping the market to develop if it ‘assured’ specific products.

The Commission has published a summary of the responses to the Call for Evidence, which describes in more detail the views of the industry.  

Demand- and supply-side issues

The Commission’s view is that the lack of pre-funded long-term care insurance products is linked to a range of demand and supply side issues. These demand and supply issues also interact. The combination of these factors has led to the industry struggling to design products that are affordable and attractive to consumers.

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5 Summary of Responses to the Call for Evidence, Commission on Funding of Care and Support, 2011, pp. 18–21.

## Figure 3.2: The key demand- and supply-side barriers to the development of pre-funded long-term care insurance

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<td>The high costs/poor affordability of products</td>
<td>Uncertainty over unit cost of care now and in the future</td>
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<td>Competition with other ways of saving (e.g. housing and pensions)</td>
<td>Risk of changes in the probability of needing care (e.g. common shocks, such as medical advances that prolong the life of people in care that would apply to the entire risk pool)</td>
</tr>
<tr>
<td>Misconceptions over state support (e.g. belief that it is free), ignorance of the risk of needing care and preference to taking a risk</td>
<td>Uncertainty about the future numbers of people needing care (in terms of longevity and morbidity)</td>
</tr>
<tr>
<td>Uncertainty about the state offer now and in the future</td>
<td>Adverse selection (those people demanding products have more information about their expected future care needs than the suppliers)</td>
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<tr>
<td>Low preference for insurance</td>
<td>Moral hazard (insurance-induced demand)</td>
</tr>
<tr>
<td>No desire to think about social care</td>
<td>Perception of excessive regulation</td>
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<tr>
<td>Preference for care from family</td>
<td>Complexity of products require advice</td>
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<tr>
<td>Necessity to obtain financial advice to access products</td>
<td>Lack of qualified independent financial advisors (IFAs) to give holistic advice</td>
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<td></td>
<td>The tax treatment of long-term care financial products</td>
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For new products to develop and the sector to play a more significant role, the Commission believes that it is necessary for the state to take on a significant proportion of the tail-end risk, as this is where the greatest uncertainty lies for private sector. Capping the risk will reduce the exposure to risk (care costs, longevity, morbidity, common shock, etc) that the sector would face if it expanded into this market, tackling some of the key supply-side barriers.

Given the uncertainty of having to write long-term contracts in this area, we think that insurers will always be wary of entering this market. There is a high risk of reputational damage if calculations prove to have been wrong and the insurer then fails to deliver on its contract. In contrast, the state has a different type of contract with individuals. It can offer the promise of protection against very high care costs, but is also able to modify the terms over time, for example as it does with the state retirement age.

If any private market is to grow significantly, it will also be necessary to address the complex demand-side issues. The difficulty of overcoming these barriers should not be underestimated; it will require time and investment by the state and private sector. This is why we believe it is important that the state offer stands alone, offering people protection against catastrophic costs without the need to buy a specific product.

**The opportunity**

The Commission has tested its proposed reforms with a number of senior figures within the financial services industry. There is considerable appetite to enter the market, if the conditions allow for the development of sustainable products with reasonable levels of risks and uncertainty. Our discussions with the industry suggest that if the overall risk was capped by the state, financial products could emerge both to support people in making their contribution and for top-up insurance.

By capping the risk at a realistic level, we think a range of financial products – linked to pensions, saving, insurance and housing equity – could emerge. Different products will be appropriate for different cohorts and groups of people – no single product will fit everyone’s need. We also know that it will be rational for some people to decide to self-insure against the risk of needing care. The Commission does not believe that it is the role of the state to design specific products; this is what the market does best.

Having said this, the proposals put forward by the Commission for the reform of the funding system are not dependent on the development of
new financial products. We know that it will take time for this market to develop, and that one product will not be appropriate for everyone.

**Products**

Indications from the industry suggest that once there is a stable offer from the state, people are made aware of the need to plan to make a contribution and the tail-end risks are capped, a new market can develop. We look to the industry to consider the best way of meeting this demand.

We hope to see a variety of different products entering the market, taking into account the needs of different segments of the population. Products should ideally emerge to support those of different ages and different income levels, and we expect that the product design, benefit level, protection cover and distribution channel will vary accordingly.

Our view is that specific products linked to pensions and to housing, the two largest and most commonly held forms of wealth, are likely to be the most attractive. We believe that it makes most sense for people to save more generally for their later life during their working life, but that products should be available which allow them to access these assets effectively, should the need to pay for care arise. Housing and pension assets are also treated more favourably under current tax regulations.

The Commission also tested public views towards planning and preparing for making contributions. Approaches varied – notably in relation to wealth, attitudes to saving, level of financial capability, acceptance of the need to take personal responsibility and attitudes towards risk. In general, however, people were more likely to be attracted to financial products with which they were already familiar. The most favoured approaches were insurance or pensions, although some were also prepared to take the risk and self-insure. More detail on the responses to the deliberative research can be found in the full TNS-BMRB report.7

**Products linked to pensions**

Disability linked annuities could become an attractive product in the future. These work by reducing the income from an otherwise flat annuity (say by around 10%) but then doubling or trebling income at the point of developing a care need (e.g. failing three activities of daily living). The advantage of such a product is that it changes the shape of a flat annuity, meaning that it is more appropriate for someone throughout their retirement. These products were on the market in the 1990s, but were withdrawn after only a couple of years as the Inland Revenue withdrew its approval (due to tax rules at that time).

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7 *Public Engagement Exploring Care and Support Funding Options*, TNS-BMRB on behalf of the Commission on Funding of Care and Support, 2011.
There is currently a lack of clarity over the tax treatment of disability linked annuities within the market, although the Commission understands that they are allowed under the pension rules introduced in 2006. We recommend that the Government makes a clear statement to this effect.

**Products linked to housing assets**

We think that many people may decide to use a part of their housing wealth to meet their contribution. We know that people are very upset by the thought of losing their homes to pay for care. Once costs are capped, however, people may decide that it is best to plan to use some of their housing assets – given this is a large block of savings. For many, even after having paid up to the cap, significant housing assets would still remain.

To release housing equity, some people may decide to downsize, others to take out an interest-only loan secured on the house. Equity release may be attractive for some people, and the industry may develop new mortgage-based solutions specifically to meet this need in the future.

**Products linked to insurance**

The industry has also said that there may be opportunities to convert critical illness cover or life insurance policies to offer cover for care costs. These products are likely to be assurance/indemnity-based products, which pay out a certain amount of money on reaching a level of need. Such products may be attractive to the industry because they build on existing products that people take out during their working life. This means that the price could be lower, as adverse selection risks will be lower (due to people taking out products earlier in life). Distribution channels could also be simpler for such products, leading to greater uptake and scale. Regulation around this area would need to be reviewed by the FSA, if the industry decided that such convertible policies were attractive.

The market for pre-funded long-term care insurance has struggled to develop. Our view is that one of the key problems is the length of time over which contracts are written, and the uncertainty that this brings. Products are expensive, and there are significant reputational risks to insurance companies if they are unable to deliver on their contracts. For this reason, we do not think it is likely that there will be significant growth in specific, pre-funded long-term care insurance products.

One insurance area that could potentially grow is top-up insurance. These products could provide an extra amount of money to supplement the amount that people spend on accommodation and general living. Once people know that they have a base level of cover, they may start to consider the type of accommodation that they want and look at ways to plan for a higher standard.
Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support

Products for those with a pre-existing condition
Once people have made their contribution up to the cap, they will benefit from free at the point of need care from the state. This element of the system is a form of social insurance scheme and is therefore risk blind. People could also benefit from the state backed deferred payments scheme regardless of ill health.

As with other types of risk-based financial products, we do know that some people with a pre-existing condition may be refused cover or have to pay premiums that are more expensive. However, we expect that new mortgage-based/equity-release type products will emerge over time, which people with pre-existing conditions will be able to take out in order to support them in meeting their contribution.

Products for those of working age
We expect that in the future, the financial services sector could develop products which would offer protection for people against care costs during their working life as well as later life. For example, critical illness policies could pay out lump sums to cover the costs that an individual faces should they develop a care and support need at any given point in their life.

Auto-enrolment
Some within the industry favour compulsory, or auto-enrolment, mechanisms. Our deliberative research also indicates that some people would like to be encouraged into taking out a product – it is seen to be simpler and more straightforward than working out how to make provision on their own. Our view is that the concept of auto-enrolment is still relatively new to the public, and is only realistically viable once the majority of people understand the need to be covered and may already have taken out a product. The Commission recommends that the Government monitor the progress of the National Employment Savings Trust, and the development of the private market under our proposals, before taking a decision on whether auto-enrolment into a long-term care product is advisable in the future.

Risk management
We think that there is significant potential for the industry to use its expertise in risk management to help stimulate better planning, early intervention and prevention activities. For example, we know that there are moves in healthcare insurance to encourage people to live healthier lives by subsidising gym memberships or offering reduced premiums if people can prove they are doing certain things. There is no reason that the same principles cannot be applied to this area.

It may be that financial products emerge which support people when they first develop a care need (e.g. at lower eligibility levels than the state
system) and then cover people up to when the state takes over. With such products, providers have a real incentive to manage the risks and prevent someone’s needs from escalating, to reduce their overall costs. We also know that once someone has bought a financial product, the provider has a closer relationship with that individual and should be able to provide further information and advice on how to stay independent for longer.

**Regulation**

The introduction of the capped-cost element significantly changes the space for financial products. The products that emerge may look very different to pre-funded long-term care insurance products of the past, and the risks associated with the products are likely to be different. For example, some of the pre-funded long-term care products in the past were investment based and therefore required a more highly qualified IFA.

Of course, it will be necessary to ensure that there is appropriate regulation to protect people, especially in this area where there may be vulnerable people needing financial advice.

We recommend that the FSA review the regulatory framework in the light of any funding reforms to ensure that it is appropriate and measured. It should also consider possible interactions with the regulation of pensions.

**Tax treatment of products**

There are three major tax-favoured forms of saving in the UK at present – pensions, housing and individual savings accounts (ISAs). Given that there is already an understanding within the population of the advantage of saving in these vehicles, and that the regulatory framework is established, the Commission believes that it makes sense to develop products to help people with social care costs which build on these three structures.

The Government, of course, may take the decision that it wishes to encourage specific products to cover the cost of care. Our view is that for this to work, it would require a tax environment that put these products on a par with other tax-favourable products. Even if preferential tax treatment was introduced for pre-funded care insurance, entirely new products might be at a disadvantage compared with products that built on housing or pension wealth.8

8 Furthermore, it is not clear that tax incentives would be effective. Courtemanche and He have found that the loss in tax revenue from granting the incentive in the US exceeded the reduction in Medicaid expenditures, suggesting this is not the most effective way of expanding the market. See: ‘Barriers and opportunities for private long-term care insurance in England: What can we learn from other countries?’, Comas-Herrera A, Butterfield R, Fernández JL et al., in Elgar Edward Handbook of Health Policy, Costa-Font J and McGuire A (eds), Elgar Edward, 2011 (forthcoming).
Interactions with the state system
Given that the Commission is recommending that a new, more objective, national assessment scale is introduced to support our recommendations, there is an opportunity for the financial services sector to work with Government in designing this scale. Ideally, we would want the financial services industry to be able to use the same scale as local government, as this will make the whole system easier to understand and more transparent. We also think it would improve public confidence in financial services products.

Wider financial services environment
The Commission is aware that the wider environment for the financial services sector is also changing and may affect the development of products. The Retail Distribution Review is likely to have an impact on the way in which products are distributed; the Solvency II directive may affect the supply of annuities and the pricing of capital. The EU has also now ruled that insurers can no longer offer gender-specific premiums. This could have a significant impact on long-term care given the varying probabilities of needing care between men and women. The ruling will come into force on 21 December 2012. It is not within the Commission’s remit to comment on these developments, but the industry will need to consider their impact when deciding which products to develop.

Recommendations
The Commission believes that our proposed reforms to the funding system will facilitate the development of financial products. Our proposal will cap the risks faced by financial services providers, which will tackle the major supply-side issues. The move towards a national framework for eligibility and assessment, and a clear ‘target’ for people to cover, should also have a positive effect on some of the demand-side barriers.

In the short term and for those currently close to needing, or already needing, care, people will need to continue to rely on their existing savings, release housing assets or take out products that are already on the market (although the cap very substantially reduces the scale of their risk). However, in the longer term, we believe that there is scope for different types of product to emerge. Future cohorts, for example, may be attracted to products linked to pensions or savings.
In order to help the market develop, the Commission specifically recommends the following:

- HMRC clarifies the tax treatment of disability linked annuities to further encourage activity in this space and we recommend that the Government makes a clear statement that disability linked annuities are permissible under current pension taxation rules.

- The Government should set up a working group of central government, local government, the financial services industry, the FSA and interested third-sector organisations to consider how to a) enable the development of an effective market and b) support consumers in making sound choices. We would expect the group to look at a range of issues, including: the regulation of the market, the IFA qualification framework, product design features, the development of common definitions, distribution channels, assessment scales (and whether the sector can use the same scale as government to improve transparency) and the impact of wider changes within the financial services environment.

- To support the industry in managing the risk and pricing products, the evidence base for social care should be improved. Poor data provision (e.g. on areas such as duration of care need) is likely to lead to more conservatively priced products. If the Government sponsors a general survey, to aid its policy development and performance monitoring, the financial services sector should be able to use this information when calculating risks. In addition, the sector will be able to utilise its actuarial skills to segment and profile risks. Given the potential gains for both the Government and the sector, we suggest that the two should collaborate in the design and use of future research in this area.
Part 4:
Next steps
4.1 Introducing reform

Implementing with pace

The Government has stated that it wishes to take forward reform of the funding of the care and support system, alongside reform of the social care statute and its own policy vision,¹ in a White Paper later this year. A Social Care Bill will then follow.

It is for the Government to decide how to take forward reform, although given the current problems with the system, we recommend that changes are implemented as quickly as possible. There have been several successive attempts at achieving social care reform over the last 15 years or so. We urgently need a new settlement.

We urge the Government to consider which elements of our reforms can be taken forward immediately, in order to help alleviate the problems of the current system. The Government should also outline its timetable for wider reform at the earliest opportunity.

There are a number of different ways of introducing the capped cost scheme and it is for the Government to decide on how it wishes to do this. It is our view that when the scheme is introduced, certain groups could already be deemed to have met the cap. These could include: all those who have been in residential care for two years already;² all those born with a disability; and all those who have a care and support need and are under the age of 40. We understand the need to assess the notional package of all those currently receiving care and support in addition to those entering the system for the first time will put significant pressure on local authorities, and consideration will need to be given to how best to manage this process.

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¹ As set out in *A Vision for Adult Social Care*, Department of Health, November 2010.
² This represents around £35,000 of care costs.
## A timetable for reform

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
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<tbody>
<tr>
<td><strong>July 2011</strong></td>
<td>Commission on Funding of Care and Support reports</td>
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<tr>
<td><strong>December 2011</strong></td>
<td>Government publishes White Paper bringing together our work, that of the Law Commission and the Government’s vision for adult social care</td>
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<td>Government to set up three working groups:</td>
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<td></td>
<td>- One to develop a more objective, portable, national eligibility and assessment framework, and consider how this may align with disability benefits</td>
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<td></td>
<td>- One to look at how to support the development of new financial products</td>
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<td></td>
<td>- One to design a new national and local framework for information and advice for those who need care and for carers</td>
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<tr>
<td><strong>2012</strong></td>
<td>Government introduces the social care bill</td>
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<tr>
<td></td>
<td>Government sets out a firm timetable for the introduction of reforms – including the capped cost element and changes to the means-tested system</td>
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<td></td>
<td>Government runs an awareness-raising campaign and starts to implement an improved information and advice service in collaboration with stakeholders</td>
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<tr>
<td><strong>2013 onwards</strong></td>
<td>Implementation of changes to the funding of adult social care</td>
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4.2 A resilient system for the long term

The basis of a long-term settlement is ensuring that people have some certainty that the same system will be in place when they may need some care and support. Without such a commitment, we do not think that people will be encouraged to save, and we are doubtful that the financial services industry will commit to taking forward the development of new products.

Having said this, it is important that there are levers that the Government can pull within the overall design so that it can respond to different pressures. We believe that our proposals allow for adjustments over time in several ways:

- The overall level of the cap can be modified over time, within reason. Obviously, it would be unreasonable for the cap to suddenly jump from £35,000 to £100,000 from one year to the next. Stability is critical to the overall success of the reforms. However, it could change over time with changing economic and demographic circumstances. As our overall wealth increases, with better information and advice, and if the financial services sector develops, the cap could be slowly increased as people plan and prepare better to meet the costs of care. Equally, if a government decided that it wanted to spend more on care and support, it could decide to lower the cap.

- The level of the contribution to general living costs could be changed as living standards and incomes change over time.

- Eligibility thresholds can be changed. We would not recommend that the Government becomes any less generous than substantial (as defined within the current Fair Access to Care Services system), as people might still be left facing very high care costs before they become eligible for support. However, central and local government could decide to make it more generous. The Government, and local government, could also decide to devote more resources to early interventions and universal services.

- The Government also has some flexibility over where it sets the thresholds and tapers within the means-tested system.

In terms of the cap, we suggest that the Government consider uprating it yearly on the same basis as the basic state pension (i.e. it follows the ‘triple lock’ rule and increases at the highest of average earnings, inflation or 2.5%).
Furthermore, we believe that the Government should consider asking an independent body to review periodically the overall level of the cap. If the Government decides to ask an independent body to review the state retirement age, it may also ask the same body to review the level of the social care cap. It would then be for the Government to decide whether it accepts the recommendations of the review body.

Both of these measures would help to build public confidence and reduce uncertainty. They would also support the financial services sector design and pricing of products, and help individuals and families in their financial planning.

**Evaluating the system**

For the Government to make decisions about how to further define the detail of the system and adjust in future, it will require timely and robust data. From the outset, we think that it is important for the Government to give consideration to the information which it will use to evaluate the system.

Currently, the area suffers from a lack of robust data, particularly at a national level and compared with other sectors (such as pensions, health and education).

We strongly recommend that key national survey data continues to be collected (e.g. the English Longitudinal Study of Ageing and the Wealth and Assets Survey), as this will be the basis of future policy-making. Such data would also assist the financial services industry in pricing products accurately and fairly.

Additional studies on care and support – specifically around length of stay in different care settings, unmet need and care packages – would be highly beneficial to the sector, financial providers and government.
Annexes
Annex A: Overview of the modelling used by the Commission

The Commission has drawn on a wide range of sources of evidence during its inquiry, including academic research, public opinion research, deliberative research and our Call for Evidence. One of the key contributing elements is modelling of current and future costs of the care and support system in England.

The Commission has drawn on three different forms of simulation models, providing different approaches to modelling what is a very complex area. They are the Personal Social Services Research Unit (PSSRU)\(^1\) microsimulation model (which looks at over-65s), the PSSRU aggregate models (for younger and older adults) and the University of East Anglia (UEA) CARESIM model (for over-65s).

This annex provides a description of the different models and the sets of assumptions they use. Further detail on each model is available in the publications listed at the end of this annex.

Future costs are by their nature difficult to model and rely on large numbers of assumptions. In all cases, changing the assumptions will change the results. The results therefore should not be taken as precise predictions of the future, rather they help to provide projections based on assumptions and offer comparisons between alternative policy options. That is why we have commissioned analysis from different sets of models to allow us to compare results, and why we have carried out sensitivity analysis to help us to understand the range of uncertainty that surrounds the projections.

The PSSRU modelling presented in this report was commissioned as part of the core programme of the policy research unit in economics of health and social care systems (also referred to as ESHCRU at the University of York, the London School of Economics and Political Science (LSE) and the University of Kent), and builds on the microsimulation and aggregate models originally developed by the PSSRU at the University of Kent and LSE. The work was funded by the Department of Health. The UEA CARESIM model has been developed through research funded by the Nuffield Foundation and as part of the Modelling Ageing Populations to 2030 (MAP2030) project funded under

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\(^1\) The Personal Social Services Research Unit (PSSRU) carries out independent research aimed at improving the equity and efficiency of health and social care. It has branches in three UK universities, the University of Kent at Canterbury, the London School of Economics and Political Science and the University of Manchester.
a grant from the New Dynamics of Ageing Programme, a cross-research council programme. Specially commissioned analysis for this report was funded by the Commission.

**PSSRU dynamic microsimulation model**

**Overview of how the model works**

The PSSRU dynamic microsimulation model projects forward consecutive cohorts of older people, modelling their health, wealth, income, and care and support needs over time.

The model starts in 2007 with a population aged 65 and over in England, drawn from the British Household Panel Survey (BHPS). The model then ‘ages’ this population one year at a time, passing every individual in the population through a series of simulated transitions. These cover their health (disability state), marital status and household composition, informal care receipt (whether co-habitants or non-household members offer care), and pension and benefit receipt.

With their health and demographic characteristics derived each year, the model then determines whether individuals ‘need’ formal care and, if so, how much, and the level of financial support for the services to which they are entitled. Individuals then decide how much care to consume based on their assumed demand for care and its cost. Their income and wealth are then adjusted according to their care spending (and other assumptions about income and wealth growth and decumulation over time). With every individual’s final care package calculated, the model then moves into a new year, and the process starts again.

Outputs from the model are calibrated with administrative data from the state-funded care and support system, and with estimates of private sector activity for the base years (up to 2010). Projections of future years are subject to uncertainty which increases as the projections move further from the current year.

**Strengths and limitations of the model**

The model is a dynamic microsimulation model, which means that it allows us to understand the implications for individuals of alternative policy scenarios in the present as well as through time. It also allows the analysis to describe people’s ‘care paths’ in time, it can provide distributional analysis – comparing outcomes across systems for different

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2 In order to maintain a full population aged over 65, new individuals (aged 65) are added to the population each year. This ‘replacement’ with new 65-year-olds can also be switched off, in which case the model simply runs until all individuals in the baseline population are simulated to have died. The number of new people introduced each year is calibrated to match (net of deaths) the national projections regarding the size of the population in this age group each year.
groups of people – and it allows us to simulate how individuals’ assets are depleted, giving information on the profile of assets used over time. It can also include demand effects, i.e. it allows the results to reflect how individuals respond to policy changes in terms of changes in their demand for care services.

The Commission asked the Institute for Fiscal Studies (IFS) to carry out a review of the model which found that the model does seem fit for the Commission’s purposes. They noted that the model captures most of the important transitions which will affect care requirements and that, where there are omissions in the model, these are largely justified by the complexity that their incorporation into the model would involve.

The model only covers adults aged 65 plus – although the issue of asset depletion is most relevant for the over-65 user group who (in contrast with younger disabled people) in the main accumulate significant assets by the time they become dependent. With the model focusing on public and private expenditure on care services, it does not explicitly include projections of assessment and care management costs – although these are covered in the aggregate modelling (see below).

The demand assumptions are important and add sophistication to the model as individuals’ willingness to pay for their own care will be a major determinant of the costs of any reform. But very little evidence on the quantification of this is available, either in England or internationally, meaning that, as the IFS review notes, these assumptions need to be treated with caution and it is sensible to carry out sensitivity analysis in this area.

While responses of demand for formal care services are simulated in the model, wider behavioural effects cannot be. For example, the model assumes that the wealth of new 65-year-olds is exogenous to the system of funding for long-term care. This means that working-age adults are assumed not to save more or less in response to any reforms to the current system. This assumption seems reasonable for individuals who are currently in their early 60s, who would have little time to respond to changes in the system, but may be less plausible for individuals currently in their 40s and 50s, who may be able to alter saving patterns in response to any reform.

Another limitation is that the assumptions around the income and wealth of future cohorts are relatively simple: the model bases the

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4 An assumption of no demand effects, however, would appear unrealistic.
levels of wealth owned by new 65-year-olds who enter the model on the previous cohort in the model (although allowing for uprating), and rates of home ownership are assumed to be constant over time. It may be beneficial in the future to link these assumptions more closely with the results of income and wealth simulations in other models, and results from such modelling will be fed into the PSSRU model more directly in further development stages. For example, recent income simulations conducted by the IFS using English Longitudinal Study of Ageing (ELSA) data, 5 projecting the income of the over-65s forward to 2017 (using existing individuals aged 50 and over), projected each successive cohort of individuals reaching the age of 65 to have substantially higher private incomes than those preceding them.

The aggregate modelling (see below) does take account of changing home ownership, using results from CARESIM, so in using all three models in our costings we attempt to take account of such trends.

**Key assumptions used in the model**

**Assets and pension incomes**: home ownership rates and the value of housing and non-housing assets are given for the baseline year according to the values in the BHPS. Assets and incomes are calibrated with data from ELSA. Assets and pension incomes are uprated by 2% in real terms per year (non-pension benefits are uprated by the Consumer Prices Index (CPI)). Assets of incoming cohorts are uprated by 2% in real terms with no trend effects – a simplifying assumption discussed above. Non-care, non-housing assets are decumulated to achieve a 3% cohort non-housing asset reduction per year.

**Demand for care services**: analysis of ELSA, as outlined in the Wanless Review (2006), was used to give all people a set of preferences regarding whether and how much they would pay privately for different levels of care. These preferences vary by their wealth and need characteristics.

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Household composition and marital status: whether individuals live with a spouse and/or child is likely to be a critical determinant of whether or not older disabled individuals receive informal care. This is sampled directly in the BHPS at baseline. A little over 35% of the older population live alone at baseline, and nearly 55% are married (including cohabiting). Informal care by people living outside the home is imputed using data from ELSA.

Longevity: probabilities of death by age and gender are taken from Government Actuary’s Department (GAD) 2006 principal population projections. Individuals are assigned a mortality risk score based on disability, need, age, sex and time spent in care, which also includes a random component to reflect the fact that not all people within each age-sex group are equally likely to die.

Prevalence of disability: disability is a crucial factor in considering need for long-term care, as it is disability rather than age which influences need for care. The baseline assumption made in the PSSRU model is that there will be constant age-sex prevalence of each need level in the population. This corresponds to the 'no change' scenario in the Wanless Review (2006), in which ‘prevention strategies and effective treatments simply offset the negative influences of obesity and other cohort trends that increase the prevalence of stroke and coronary heart disease (CHD)’.

IFS analysis of all available waves of ELSA, carried out for the Commission as part of the review of the PSSRU microsimulation model, finds that constant age-sex prevalence of disability is not an unreasonable starting assumption, based on recent trends.

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6 See, for example, Sources of informal care: Comparison of ELSA and GHS, Pickard L, PSSRU Discussion Paper no. 2598, 2008.
However, the latest UK research on trends in prevalence of disability suggests that this may be an optimistic assumption. In her submission to the Commission, Professor Jagger of Newcastle University notes that changes have occurred in CHD and stroke mortality alongside increases in risk factors for these, and other, diseases, notably obesity. Together with changes in mortality, this implies a larger pool of survivors of stroke and CHD with their associated disability. Additionally there is evidence that the prevalence of a number of other disabling diseases is increasing, for example arthritis and diabetes (although the disability associated with the former may be reducing). Therefore the central health scenario developed as part of the New Dynamics of Ageing project Modelling Ageing Populations to 2030 (MAP2030) assumes that the overall prevalence of disability increases by 3 percentage points over the next 20 years (from 11% in 2010 to 14% by 2030).

Given the uncertainty in this area it is important to carry out sensitivity analysis – see Part 2 of the report for the results of modelling on this using the aggregate models described below.

**Receipt of disability benefits:** BHPS data are used to predict (using 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. The model’s estimates of AA and DLA uptake and spend are then triangulated with Government published figures for these benefits.

**Unit costs of care:** the unit cost of residential care is assumed to be £550 per week (2009/10 prices) and the unit cost of domiciliary care to correspond to £15.50 per hour. Unit costs are uprated by 1.5% in real terms to 2017/18 and then by 2% in real terms onwards.

**PSSRU aggregate models: younger and older adults**

**Overview of how the models work**

The PSSRU long-term care projection models aim to make projections of four key variables: the future numbers of people with disabilities, the likely level of demand for care services and disability benefits, the costs associated with meeting this demand and the social care workforce required.
The models do not make forecasts about the future. Rather, they make projections on the basis of specific assumptions about future trends. The models are cell-based (macrosimulation models). They first estimate the numbers of people with different levels of disability by age group, gender and household composition. Then they attach a probability (for each subgroup by age, gender etc) of receiving informal care, formal care services and disability benefits. They then estimate gross and net social services expenditure, expenditure on long-term health services (for older people only) and costs of disability benefits. They also each have an element relating to the social care workforce.

Strengths and limitations of the models
The advantage of these aggregate models is that between them they cover adults of all ages, and they also include projections of assessment and care management costs. They are simpler in structure than the microsimulation model, and so easier to understand and interrogate. But by implication they lose some degree of sophistication compared with the microsimulation approach. Therefore they cannot model care pathways or individual responses to policy changes.

Key assumptions

**Household composition and marital status:** marital status rates for physically disabled younger adults change (to 2030) in line with GAD 2008-based marital status and cohabitation projections, while those for learning disabled people remain constant. There is a constant ratio of single people living alone to single people living with others. Family Resources Survey (FRS) data were used to estimate the likelihood of receipt of informal care in the community.

For older people, the GAD 2008-based marital status and cohabitation projections were used. They were supplemented with data on household composition within marital status group and receipt of informal care from the 2001/02 General Household Survey (GHS).

**Housing tenure and home ownership:** rates for older people are taken from FRS data, with projections taken from the CARESIM model.

**Longevity:** the number of people by age and gender changes in line with the GAD 2008-based principal population projections.
Prevalence of disability: For younger adults, prevalence rates of learning disability by age and gender change in line with the projections by Emerson and Hatton (2008) and the prevalence rates of physical disability by age and gender remain unchanged as reported in the 1996/97 FRS.

For older people the model uses data from the 2001/02 GHS. Prevalence rates of disability for older adults by age and gender remain unchanged in the base case. See above for further discussion on this assumption.

Receipt of care services: Census 2001 data and official data on numbers of supported residents were used on numbers of younger adults in communal establishments, by age, gender and marital status. Data on the prevalence of learning disability and on the socio-economic characteristics, severity of disability, use of services and receipt of benefits for young adults with learning difficulties were obtained from the survey Adults with learning difficulties in England 2003/4 (Emerson et al., 2005). FRS data were used to derive an estimate of the prevalence of physical disability among 18 to 64-year-olds in England, as well as to break down the younger physically disabled population by age, gender, marital status, living arrangements and level of disability. FRS data were also used to estimate the likelihood of receipt of formal care services for physically disabled adults. Official data were used on the numbers of service users by client group and on expenditure on social services.

For older adults, official national statistics were used on the total numbers of local authority supported residents in residential care and nursing homes in England, the overall numbers of supported users of community services, and gross and net expenditure on social services. The probability of receipt of each non-residential service for older adults was estimated through multivariate (logit) analysis of the 2001/02 GHS data.

Receipt of disability benefits: FRS data were used to estimate the likelihood of receipt of benefits for younger adults, while for older adults GHS data were used. Estimates from these sources were grossed to match Department for Work and Pensions (DWP) administrative data.
The proportions of adults receiving informal care, formal community care services, residential care services and disability benefits remain constant for each sub-group by age, gender, client group, disability and other needs-related characteristics.

**Supply of formal care:** this is assumed to adjust to demand, with demand assumed to be no more constrained by supply in the future than in the base year.

**Unit costs:** the real unit costs of social services rise by 2% per year in real terms from 2015 onwards, (except for non-labour non-capital costs which remain constant in real terms), and DLA and AA rates remain constant in real terms. From now until 2015, real unit costs are projected to remain constant in real terms.

**CARESIM**

**Overview of how the model works**

CARESIM is a microsimulation model which uses a pooled sample of 25,747 people aged 65 and over living in England from the 2002/03, 2003/04 and 2004/05 FRS. CARESIM uses information on sample members’ incomes, assets (including estimates made within the model of their housing wealth) and other relevant characteristics. The information is used to simulate sample members’ income tax liability, entitlement to means-tested benefits and then their liability to pay for care, should care be needed, under the current and alternative means tests for care charges.

The simulations are performed for a base year and for future years. For future years, the sample is then ‘aged’. Death of sample members is simulated according to official age and gender-specific mortality rates, using Monte Carlo techniques. The evolution of gross incomes and capital is modelled under certain assumptions and taking account of the inheritance of pension rights and assets when a partner is simulated to die.

The simulations of liability to pay for care are performed for three different kinds of care homes and four different levels of home care need. In order to allow for depletion of capital once a sample member starts to pay for care, lengths of time in care homes or in receipt of home care (measured in weeks) are assigned to sample members, again using Monte Carlo techniques. The distribution of uncompleted lengths of

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7 Pension Credit, and for those living in their own homes, Housing and Council Tax Benefit.
time in care homes is based on analysis of the 2000 Health Survey for England which included a sample of care homes. The distribution of lengths of time in receipt of home care is based on analysis of data from the PSSRU’s extension to the Information Centre’s 2006 Older People Receiving Home Care User Experience Survey. Both sources record these durations in bands with little detail on the upper end of the distributions.

Monte Carlo techniques are also used to assign entitlements to AA/DLA for each of the categories of care receipt. The prevalence of receipt of AA/DLA among home care recipients, by intensity of home care, is based on analysis of the 2001/02 General Household Survey (GHS), carried out for the PSSRU aggregate model and grossed by the ratio of numbers of AA/DLA recipients from DWP data to numbers estimated from the GHS. Given a lack of up-to-date data on receipt of AA/DLA in care homes, alternative assumptions are made (see below).

CARESIM output is weighted so that the proportion of the sample receiving each kind of care matches that projected by the PSSRU aggregate model for population sub groups defined by age, gender, tenure and marital status.

**Strengths and limitations of the model**

The model has detailed data on individual incomes now and over time, and allows us to look at individual level implications of policy changes. It can also be linked with the PSSRU aggregate older people’s model to look at both aggregate and micro-level comparisons between policy options. Results from the models provide point-in-time estimates of public and private expenditure on care and of changes in care users’ disposable incomes. They indicate first round effects and do not allow for demand for or supply of care homes to respond automatically to changes in the funding system.

As for the PSSRU microsimulation model, the model looks only at older adults – using a sample of those aged 65 and over. Because it is more difficult to predict the future incomes of people who are not yet retired than it is for those who are already drawing pensions, the sample is not refreshed. So by 20 years from the base year, the simulations are representative only of people aged 85 and over. But it is at these oldest ages that the need for care is highest, and the proportion of people living in care homes rises sharply. This restriction is therefore not as limiting as it might seem.
Key assumptions used in the model

**Assets and incomes:** these are initially as recorded in, or estimated from data from the 2002/03, 2003/04 and 2004/05 FRS, uprated to base year prices. For future years, the model assumes that all existing owner-occupiers remain owner-occupiers unless or until they need to draw on their housing wealth to pay for residential care. Housing wealth is assumed to grow at the same rate as real earnings. Private sources of income are assumed to maintain their value against price inflation, as are financial assets up to the point where they start to be used to pay for care. Non means-tested benefit income is uprated according to recent/announced future policy. Similarly the income tax and means-tested benefit system is assumed to follow recent or announced uprating policy.

**Receipt of disability benefits:** in the absence of up-to-date data on receipt of AA/DLA in care homes, two alternative assumptions are made. The first is that in nursing homes 50% of residents are entitled to the higher rate of AA and a further 25% to the lower rate of AA/middle rate of DLA, with the corresponding percentages for residential homes being 40% and 30%. This is based on a 1999 PSSRU survey of older privately funded admissions to care homes. The second is that all care home residents are entitled to AA which they claim (and receive if they are self-funders).

**Residents’ contributions to their care home fees:** here it is assumed that they first allocate income apart from the personal expenses allowance to these costs and draw on capital (financial assets followed by housing wealth) only if income is insufficient. Any unspent income would only accumulate as capital otherwise. It is assumed that capital is not used for purposes other than the resident’s contribution to the care home fees. For self-funders in receipt of AA or DLA, the assumption is that they use that income before other income.

**Unit costs:** assumptions used in CARESIM on social services costs and AA/DLA are the same as those used in the PSSRU aggregate modelling.
References and further reading


Annex B: Contributors to the Commission’s work

Members of the External Reference Group

- Age UK
- Alzheimer's Society
- Association of British Insurers
- Association of Directors of Adult Social Services
- Carers UK
- Care Quality Commission
- Confederation of British Industry
- Counsel and Care
- English Community Care Association
- Equality and Human Rights Commission
- Independent Healthcare Advisory Services
- Joseph Rowntree Foundation
- Learning Disability Coalition
- Local Government Association
- Mental Health Foundation
- National Association of Pension Funds
- National Care Association
- National Care Forum
- National Centre for Independent Living
- National Council for Voluntary Organisations
- National Housing Federation
- NHS Confederation
- Radar
- Registered Nursing Home Association
- Shaping Our Lives
- Social Care Institute for Excellence
- The King’s Fund
- Trades Union Congress
- UK Home Care Association
- Voluntary Organisations Disability Group

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