

Fairer Care Funding

**The Report of the
Commission on Funding
of Care and Support**

July 2011

Volume I

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Foreword

It is a matter for celebration that people are living longer. For many, these are extra years of good health and quality of life. For others whose care needs grow, we see much fear and uncertainty. Caring for and supporting each other should be something to celebrate. In the life and work of individuals and carers we can see dignity and independence made possible, and much that is good about our communities and society.

Over the last year we have been talking to people and collecting evidence, and we have been told, again and again, that the system we have for funding care and support is broken and needs to be fixed. Care is the one major area of our lives where, at the moment, there is no way for people to protect themselves against the risk of high costs. We need a new system so that, instead of being fearful about the financial consequences of needing care, people can plan and prepare for the future. And those with a care and support need now should be better supported. Our reforms need to bring together public funding, private funding and unpaid care in a new, fair and effective sharing of responsibility.

We outline in our report a new model which, we believe, delivers on this vision.

Everyone who receives their care for free now will continue to do so; and we are proposing a cap, so that everyone else is protected from extreme costs, as they are in every other major area of their lives. More working-age adults will not have to pay any charges, and younger people will not be subject to a means test.

We propose a significant increase in the threshold at which means-tested support is taken away, so that extra protection is given to those with the lowest incomes and wealth.

We recommend a shift to a new national eligibility threshold, to tackle the extremes of the ‘postcode lottery’, and better assessment processes for both those needing care and their carers. We want to see significant improvement in the provision of information and advice, and more joined-up working across the whole care and support system – health, housing, benefits and adult social care.

This is a set of proposals that will concentrate help on those with the greatest needs, give peace of mind to all and create a new partnership between the public and private sectors. Individuals with care needs, carers (both paid and unpaid), the financial services sector and the public and voluntary sectors will all have a part to play. Together we can help people achieve the outcomes they want, offering choice and delivering services shaped around individuals and their families.

Our system of funding of care and support is not fit for purpose, and has desperately needed reform for many years. We were delighted to be asked to advise on this, and believe that our report sets out a way forward that is fair, effective and sustainable. There is a real chance to create a better system. Now is the time to act.



A handwritten signature in black ink that reads "Andrew Dilnot".

Andrew Dilnot

Chair of the Commission on Funding of Care and Support



A handwritten signature in black ink that reads "Norman Warner".

Lord Norman Warner

Commissioner



A handwritten signature in black ink that reads "Jo Williams".

Dame Jo Williams

Commissioner

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A definition of care and support

Social care supports people of all ages with certain physical, cognitive or age-related conditions in carrying out personal care or domestic routines. It helps people to sustain employment 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 that is used for care and support needs. The Commission believes it is important to look at care and support in the round – firstly, because we know that people want to receive a coherent package of support that is shaped around them, not funding streams and, secondly, because aligned and integrated services offer better value for money.

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 in many cases people 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 they 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 that £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 consider 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 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 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.
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

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.

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.

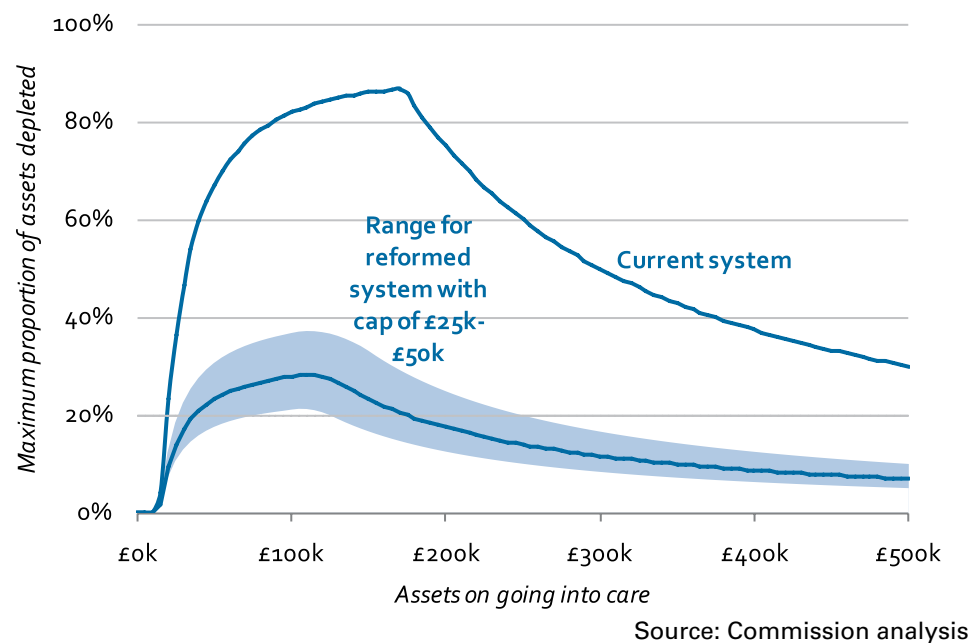
In particular, we believe it is important that there is improved integration of health and social care in order to deliver better outcomes for individuals and value for money from the state.

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. The chart below shows how making these two changes significantly reduces the proportion of assets that people face losing compared with 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 going into residential care would have to spend more than 30% of their assets on their care costs.

Figure 1: Maximum possible asset depletion under our core proposals for people who enter residential care and have lifetime care costs of £150,000²



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.

Our views on the level of funding for social care

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 the reforms we have set out will help people to manage their contribution better, for example by helping people to 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 that 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.

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.

The Commission's task

The Commission has been asked to make recommendations on how to achieve an affordable and sustainable funding system for care and support for all adults in England, both in the home and in other settings. The Commission was 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.

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.

Chapter 1: Why the system needs to change

Shortcomings of the present system

The Commission was asked by the Government to make recommendations on the reform of adult social care funding.⁴

We have gathered evidence and views on the current system and why it needs to change. We reviewed the work of previous commissions and reports on social care funding, and looked at examples of different systems from across the world. What we heard and learnt presented an overwhelming case for change.

The adult social care funding system conceived in 1948 is not fit for purpose in the 21st century and is in urgent need of reform. Having to cope with a care and support need – both emotionally and financially – often comes as a major shock. When people then experience the system, many perceive it to be unfair. This is particularly the case when people have to sell their homes, or use up the majority of any assets they have, to pay for care. The current system does not encourage or reward saving, and is poorly understood. People are not prepared, which often leads to poor outcomes and considerable distress.

The current funding system

Today, the social care system in England provides care and support through a means-tested system, which is 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 dependant still living in the home) are taken into account in the means test.

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

⁴ The Coalition Government announced its intention to set up the Commission on Funding of Care and Support in *The Coalition: Our programme for government*. The Commission's Terms of Reference and how it approached its task are described in the accompanying evidence pack.

There are many people and organisations working hard to provide valuable support to individuals and families, and there are many examples of people providing exceptional care. We particularly recognise the vital role carers play in the current system. Progress has also been made in the way that care is delivered and people now have more choice and control, leading to greater independence and improved outcomes for individuals and families. However, there are major problems with the way that social care is currently funded.

We have consulted widely throughout our work and believe there is now consensus that fundamental reform is urgently needed. There is a strong feeling that, without such reform, the current system will deliver ever poorer outcomes for individuals and families. We agree.

We also know that it is not just the funding system that is broken. There are wider problems that also need to be addressed. People have told us that there needs to be better integration of services, the current ‘postcode lottery’ of care should be addressed, there should be more transparent assessment processes, and there needs to be much better information and advice. We discuss these issues later in the report.

Issues with the current system

People are exposed to potentially very high care costs

Around one in 10 people, at age 65, face future lifetime care costs of more than £100,000.⁵ Younger adults with care needs face significantly higher lifetime costs. As a result, in paying for care, some people can lose the majority of their income and assets. In particular, those entering residential care are often forced to sell their homes – this is widely regarded by the public as unfair.⁶

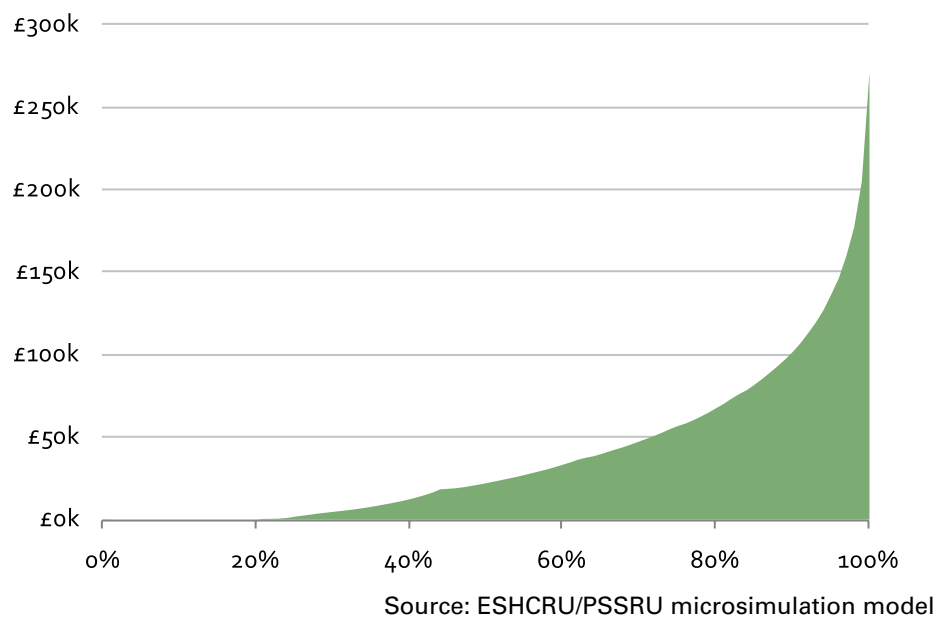
5 All care costs exclude a contribution towards general living costs for people in residential care, which is assumed to be around £10,000 p.a. Data on the costs of social care is poor, especially for those receiving domiciliary care. The source of this analysis is modelling work carried out for the Commission 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, London School of Economics and Political Science (LSE) and 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.

6 Commission on Funding of Care and Support, Call for Evidence; *Public engagement exploring care and support funding options*, TNS-BMRB on behalf of the Commission on Funding of Care and Support, 2011.

The cost of care

We estimate that a quarter of people aged 65 will need to spend very little on care over the rest of their lives. Half can expect care costs of up to £20,000, but one in 10 can expect costs of over £100,000. Some could spend hundreds of thousands of pounds. There is no way of predicting in advance what the costs might be for any one person.

Figure 2: Expected future lifetime cost of care for people aged 65 in 2009/10, by percentile (2009/10 prices)



We know that for those who are born with a disability, or who develop a care and support need during their working life, lifetime costs will be considerably higher.

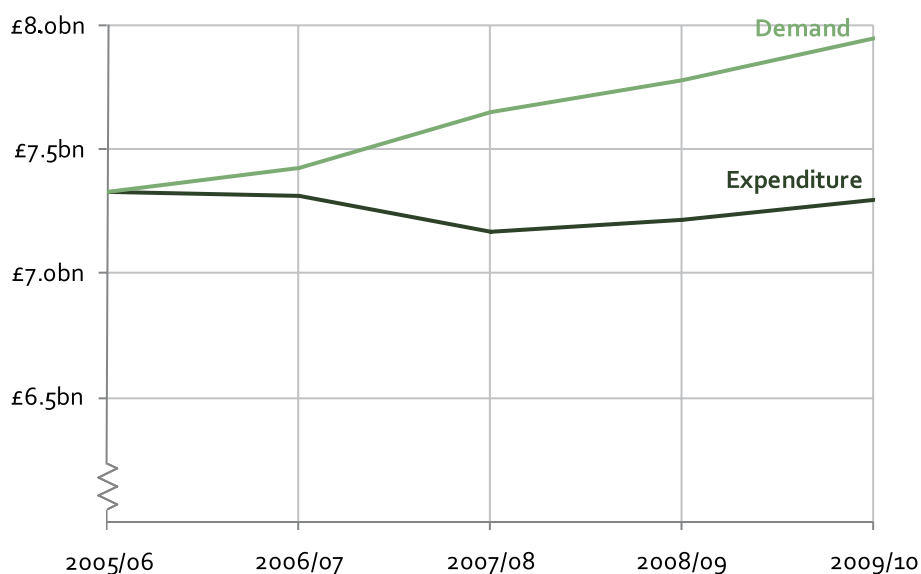
Currently, individuals cannot protect themselves against the risk of very high care costs by pooling their risk. In areas such as motoring and housing, people buy private insurance to pool their risk and cover themselves against exposure to high costs. For health care, the NHS pools risks by providing social insurance to everyone; for care costs, however, the state does not provide universal support and people are unable to take out private protection. This is the only major area in which everyone faces significant financial risk, but no one is able to protect themselves against it.

There is inadequate funding – people are not receiving the care and support they need

We consider that the current social care system is inadequately funded. People are not receiving the care and support that they need and the quality of services is likely to suffer as a result. We recognise that there is a shortage of precise data on the extent to which needs are currently met, but we do know that social care expenditure on older people has not kept pace with the increase in demand. Over the last four years demand has outstripped expenditure by around 9%.⁷

Figure 3 shows real expenditure on personal social services care since 2005/06 against projected demand. Projected demand takes account of both real unit cost growth of services (using the Personal Social Services pay and prices index) and demographic change.

Figure 3: Expenditure and demand: older people's social care (2009/10 prices)



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

We know that the funding of social care for older people has not kept pace with that of the NHS. In the 15 years from 1994/95 to 2009/10, real spending on adult social care increased by around 70% for older people while, over the same period, real spending in the NHS has risen by almost 110%.⁸ In the future this is going to need to change.

⁷ Commission analysis of *Personal Social Services Expenditure and Unit Costs: England 2009-10 – Final Council Data*, The Information Centre, Department of Health.

⁸ 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.

Taken together, these pressures are likely to mean increasing demands have been placed on the care and support system, and the quality of care may have been adversely affected.

The current system delivers inconsistent services

There is unacceptable variation in eligibility for services across the country

There are currently 152 different adult social care systems – one for each local authority in England. Entitlement to services differs across the country and people complain of a ‘postcode lottery’ of care.⁹ Different people, with similar care needs, can receive very different levels of support from their local authorities. Each local authority carries out a financial assessment of what the person can afford to pay. For residential care there are national regulations on charging, but for domiciliary care local authorities can design their own charging policies within the overall national guidance – this leads to variation.

As we gathered our evidence, we concluded that the current approach to setting eligibility and assessing care – FACS¹⁰ – lacks transparency, consistency and clarity. Although it takes into account a wide variety of factors, it does not seem objective. In particular, people are not able to work out for themselves whether or not they are likely to be eligible for local authority support and whether they have been dealt with fairly.

Assessments are 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 that new local authority. It is not acceptable that people currently feel trapped and unable to move should they want to. This does not enable people to have choice and control over their own care.

The system is complex and difficult to understand

People are not planning for the future

Currently, many people are unaware of how the system operates. Many believe they will receive free care in later life and are often shocked when they discover the scale of their financial liabilities at the point that they, or a family member, need care. Even if people are aware of how the current system works, there is little they can do to prepare for the future.

9 Summary of the Big Care Debate consultation, Department of Health, 2010 and *Public Opinion Research on Social Care Funding: A literature review on behalf of the Commission on the Funding of Care and Support*, Ipsos MORI Social Research Institute, 2011.

10 The FACS framework was introduced in 2003 to address inconsistencies across the country about who gets support. It was replaced by *Prioritising Need in the Context of Putting People First: A whole system approach to eligibility for social care*, Department of Health, 2010 – but the framework is still widely referred to as FACS. The revised guidance places eligibility criteria within a wider context of personalisation and prevention to address not only the needs of individuals but also those of the wider community.

The state does not offer protection beyond the means-tested system and there are no financial products on the market to help people prepare in advance for future costs of care. The result is that many people do not plan for meeting future care needs.

The provision of information and advice is poor

Once people, of any age, enter the system, there is very limited information and advice available, and it is often of poor quality. People can be unaware of the support and services that are available to them. There is confusion about the role of benefits, the NHS and social care. People often struggle to find financial information and advice. There is also little information and advice specifically for carers. There are examples of good practice but, on the whole, our evidence strongly suggests people are bewildered by the system and do not know where to go or who to talk to for advice.¹¹

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 younger people may be claiming other work-related benefits. People and families often face multiple assessments and poorly co-ordinated services, and the state does not achieve best value for the money it spends.

There have been attempts across the country to integrate services – and there are some examples where this has worked well. However, these examples are not widespread and many people still experience disjointed service delivery and limited choice. For example, we know that many people who wish to die at home are admitted to hospital and end their life there.¹²

11 See *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.

12 A Demos/YouGov poll in 2010 found that only 7% of people said they wanted to die in hospital, yet about 58% of deaths take place in hospital. More detail can be found in the report *Dying for Change*, Demos, 2010.

Pressures on the system

The current system is neither fit for purpose today, nor for coping with future pressures.

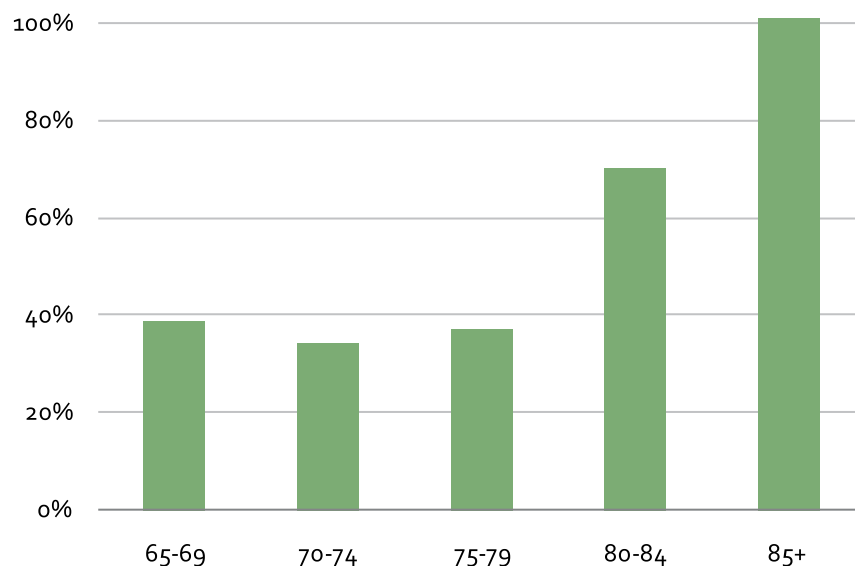
People are living longer

People can now expect to live much longer after they retire, compared with their parents or grandparents. This is something to celebrate. In 1901, there were just over 60,000 people aged 85 and over in the UK. Today there are 1.5 million – a 25-fold increase. Many younger people with a care and support need are also living longer.

There has been significant demographic change over the past century. As a society, we have managed this change and continued to prosper. However, the current system for supporting people is not working as well as it should, and now needs reassessing if it is to be fit for the future.

As Figure 4 shows, we can expect further rapid demographic change, with particularly striking increases in the number of the oldest people in our population.

Figure 4: Growth in the number of older people in England 2010–2030, by age



Source: 2008-based population projections, Office for National Statistics

Figures from the Office for Budget Responsibility show that UK public spending on long-term care (on the current, unreformed system) is expected to increase from 1.2% (2009/10) to 1.7% (2029/30) as a

percentage of total gross domestic product (GDP). This is growth of 40% – faster than any other area of age-related public spending – and is largely driven by demographic change.

As part of living longer, people can expect to need some care and support at some point in their lives. For some, this will be very limited and may come close to the end of their lives when they become very frail or unwell; others will need much more extensive support for far longer periods. Many younger people with a care and support need are also living longer, often now outliving their parents.

These trends imply that as a country we will need to provide much more care and support. This will need to come partly from increased public spending, partly from private contributions, and partly from unpaid care. The reforms we propose will support people in planning and making their contribution. They should also better support the valuable contribution made by carers.

People are better off and their expectations are rising

Not everyone will own their own home or have significant savings, and it is important that there is additional support for these individuals and families. However, in addition to living longer, people are generally becoming wealthier and expectations of the quality of care that people want are rising. A reformed funding system will help people better meet these expectations.

Given that the future is uncertain, we believe any reformed funding system for care and support will need to: be resilient to change; flex and adapt to changing pressures and demands; and meet the needs of different populations and groups. Because the adult social care funding system has been neglected for too long, it can seem arbitrary and unfair to the people who need it the most. It is now urgently in need of reform. In the next chapter we outline our proposals for how we think this should be done.

Chapter 2: A better, fairer funding system

Fairer funding

Our overall objective for reform is to: enhance the well-being of individuals, families and carers; support people of all ages in achieving the outcomes they want from their lives; and treat them with dignity and respect.

To achieve this overarching aim, 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 in which delivery is shaped around individuals, not services.

We believe that a capped cost model is the best way of achieving these aims.

Capping the cost benefits everyone

We think the best way to reform the adult social care funding system is for the state to step in and take responsibility for the area of greatest unpredictable risk. This approach means that individuals would need to take responsibility for their own costs up to a certain point but, after this, the state would pay. We see our proposals as a type of social insurance policy, with a significant ‘excess’ that people will need to cover themselves.

A minority of people would reach the level at which the state steps in – these would be those with the highest care needs over the course of their lifetime. However, everyone would benefit from knowing that, if they ended up having to face these costs, they would be covered. We believe that by removing the fear and uncertainty inherent in the current system, people would be encouraged to make sensible preparations for the future. The approach would create a new space for financial products, which could support people in making their individual contributions.

A new model of shared responsibility

Our recommended system redefines the contract between individuals and the state and has the following main elements that come together to form a clear, national offer:

- **The contribution individuals are expected to make in meeting the cost of care will be capped.** To start with, people would be expected to meet their own needs as best they can. Once their accumulated needs have reached the level of the cap, they would be eligible for a care package funded by state.
- Those who cannot afford fully to make their contribution would continue to receive **means-tested support**, which will be extended. **We recommend that the upper threshold within the residential care means test should be raised from £23,250 to £100,000.**
- Everyone would be entitled to **universal disability benefits** (which will also support people in addressing lower care and support needs).
- **Those in residential care would be expected to make a contribution to their general living costs**, just as they would be expected to meet the costs of living in their home.

Figure 5: Our proposed funding system



How will the system work?

Care for older people

The individual's contribution

To start with, individuals are responsible for meeting the costs of their own care. Targeted support, through a means-tested system, will remain in place to support those with less money to make their contribution.

In order to maximise choice and control, we want people to have different options for meeting their contribution. Some people may choose to pay for all their care through their income or savings. Others may decide to release some of their housing assets or take out a specific financial product. It would be down to individuals and their families to make personal decisions about how they want to meet their personal responsibilities.

The state's contribution

At the core of our proposal is the new capped cost element, which sets a limit on the amount individuals are expected to contribute towards their care over their lifetime. After individuals have spent a certain amount, they would become eligible for state-funded care.

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. We believe that a cap outside of this range would not meet our criteria of fairness or sustainability. Given this, we believe a cap of £35,000 is fair and realistic, and have used this as the figure for the cap throughout our report. We discuss the rationale for the level of the cap later in the report.

The capped cost scheme would work as follows:

- Everyone with a care and support need can ask to be assessed by their local authority.
- If they are assessed by the local authority as having some care needs above a defined, nationally set threshold, the local authority will work out how much it would cost to meet these needs. This would be based on the cost of a typical local authority package for that level of care, in that local area. If the individual's income and assets are low enough, means-tested support would be given.
- For those not entitled to means-tested support, the local authority would use this assessed care package to determine at what point in time the individual would meet the cap. After this point, the individual would be eligible for free care from the state.
- If someone's needs change, they can be reassessed and the time taken to reach eligibility for free support adjusted accordingly.

The state-funded care element will be based on a local authority care package, but people will be free to top up from their own resources, should they wish. If someone moved to a different local authority, they would take with them a record of their contributions to date.

Alice

An example of a person needing residential care for longer than average.

Alice lived alone in her own home worth £180,000. She had dementia and needed to go into a residential care home when she was 83 for the last five years of her life.

Under the current system

Under the current system, her daughter needed to arrange for her home to be sold in order to be able to use the money to pay for her care. She had to pay for all her care and living costs in full until she died, spending £165,000 from her pension income and housing wealth.

Under our reformed system

Under our reformed system, Alice would initially need to contribute in full to her care and general living costs. After two years, she would have contributed £35,000 towards her care and reached the cap. From then on, the state would pay her care costs of £18,500 p.a., and she would pay just for her general living costs out of her pension income. She would be able to keep 80% of her wealth.

Care for people of working age

Many people can expect to develop some sort of care and support need in their later lives, and we think it is reasonable to expect someone to prepare for this eventuality. The same cannot be said for younger people – for those either born with a disability or who develop one early in life.

At present, the vast majority of people of working age with a care and support need are supported through the means-tested system and receive state-funded care. This would continue under our proposals, as it is not reasonable to expect people to have saved for this need. Many will have low incomes and will not have had the opportunity to accumulate assets. However, those people of working age who do have private income or assets, for example from employment or an inheritance, are currently required to pay the full cost of their care.

We are keen to have one overarching system, underpinned by the same principles, as this avoids arbitrary boundaries. Two systems – one for younger people and one for older people (those over the state pension age) – could lead to unfair outcomes. For example, if there were two systems in operation, a 64-year-old and a 65-year-old with similar levels of need and the same financial position could have to make very different levels of financial contribution and have very different outcomes. We do not think this is sensible or equitable.

This is why we believe that those who develop a care and support need during their working life should be assessed in broadly the same way as an older person. However, in setting the cap, we think it should be tiered in a way that reflects differentials in the likely ability to accumulate assets.

A tiered approach could work as follows:

- Those reaching adulthood with eligible care needs, many of whom will have been born with a disability, should receive state-funded care – they have, in effect, met the cap.
- Anyone developing an eligible need up to the age of 40 should also face a zero cap, as we do not think that people younger than 40 can, in general, realistically be expected to have planned for having a care and support need, nor will they have accumulated significant assets. People may still be paying off debts, have significant amounts still to pay on their mortgage, and could have young families.
- After the age of 40, the cap should then increase up to retirement age, when the full cap of £35,000 will apply. We expect that this could rise at £10,000 per decade – so a 40-year-old could be expected to have a cap of £10,000; a 50-year-old, £20,000; a 60-year-old, £30,000; and a 65-year-old, £35,000.

Those within the current means-tested system will continue to receive state support and more people will become eligible for state support.

We also believe that there is considerable scope to simplify and streamline support, especially at the key transition from childhood to adulthood. We understand that this is a time of uncertainty and anxiety for many individuals and families. We believe that a guarantee that the state would continue to fund care in full would be reassuring to many families.

We have suggested 40 years of age as the point at which the cap starts to increase from zero, as we think by this point many people will have accumulated some wealth. It will be for the Government to make a judgement on exactly how it wishes to implement such a tiered system.

We also know that there may be some people who need care at different times in their lives, for shorter periods. We think that all episodes of care should count towards the cap, regardless of when they occur and whether they relate to the same underlying condition. Such an approach is simple and consistent with our principle of protecting people against high lifetime care costs.

We expect that, in the future, the financial services sector could develop products that would offer protection for people against care costs during their working life, as well as in later life. 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.

Emma

An example of a person turning 18 with an eligible need.

Emma was born with a learning disability. Her mother died when she was 35; she then had to move into supported housing. She inherited £150,000 from the sale of her mother's house. She died aged 52.

Under the current system

Under the current system, Emma received all her care and support free of charge up until the point at which she inherited £150,000. From then on, Emma had to use these assets, along with disability benefits, to pay for her supported housing and care and support costs. By her mid-40s, she had spent down her assets to £14,250, the means-tested threshold, and received support from the state, without charge.

Under our reformed system

Under our reforms, as Emma would have turned 18 with an eligible care need, she would be deemed to have met the cap and would receive all her care without charge for the whole of her lifetime. She would have contributed to her general living costs partly herself and partly through her disability benefits. She would spend half of the £150,000 on her general living costs, but could use the rest of the money throughout the rest of her life to improve her overall well-being.

Contributing to general living costs

Under the current system it is very difficult to disentangle the general living costs from the cost of care in a residential care setting. There is a lack of clarity about how much a care home placement costs overall – and how this cost is divided up between care and general living costs.

Under our proposals, people in residential care will be responsible for making some contribution towards their general living costs, such as food and accommodation – just as they would be expected to cover these costs if they were living at home – but a limit will be set on this contribution.

It would seem unfair that those receiving domiciliary care would no longer need to make any contribution towards their living costs if they moved to a different care setting. We want to ensure a level playing field between different care settings. However, we believe this contribution should be clear, and there should be a limit on the overall contribution.

We think that the contribution should be a fixed amount across the country. We believe that this is a fair and simple approach. Setting a limit on the amount that people have to contribute towards general living costs means it will not be possible to charge more for care and claim it is for general living expenses. This will add greater transparency to the system. This fixed contribution should be based on a judgement of what individuals could afford and what they might expect to pay for day-to-day living costs.

We have looked at a range of different figures for older people, ranging from £7,000 to £10,000 p.a. For the purposes of our analysis we have used £10,000 p.a. This is a contribution of around £190 per week. This is the maximum contribution we think any individual should have to make. We discuss this further in Chapter 3, which outlines our rationale for our proposed reforms.

To meet this contribution, older people would need to make a contribution from their income, savings or assets, in addition to their state pension. It is likely that those unable to afford to make this contribution will already be eligible for state-funded care under the means-tested system.

On average, people of working age with a care and support need have lower incomes than older people because the social security system typically provides a lower income to those below state pension age. As a result there is a larger potential gap between their income and any contribution. The Government will need to take this into account when deciding on how much any contribution should be, and whether or not different levels are needed for people of different ages.

Personal Expenses Allowance

As in the current system, no one will be expected to contribute their entire income to their residential care costs; everyone will be left with a certain amount of money for personal expenses each week. Under the current system, this amount is £22.60 a week (the Personal Expenses Allowance (PEA)). We think that the PEA should continue, but would encourage the Government to consider the case for increasing it in the future.

John

An example of a single older man who enters residential care towards the end of his life.

John had a stroke at the age of 85. He could no longer manage at home and entered a care home costing £28,500 a year. He lived in the care home for four years before he died. Prior to this, he lived on his own, in a house which he owned outright and was worth £140,000. He had £220 a week income from his own pension and the state pension.

Under the current system

Under the current system, John had to contribute all his income except for £22.60 a week and use his housing assets to pay for his care. He continued to pay for his care in full until he died, spending £74,000 from the value of his house.

Under our reformed system

Under our reforms, John would pay the first £35,000 of his care costs and after two years he would reach the cap and then receive all his care without charge. He would continue to contribute £10,000 a year towards his general living costs – but would do this all through his pension income.

He could choose to use his housing assets to pay for the £35,000 (taking out a deferred payment from the local authority), and still have £105,000 left, three-quarters of his wealth.

Reforming the means-tested system

The Commission believes that a means-tested system must continue alongside the new capped cost element. Means-tested support will need to be available for those who may not be able to afford to make their full personal contribution.

The current means-tested system is complex; it does not encourage saving for the future and many perceive it as unfair. Different local authorities have different charging policies for domiciliary care and can choose to support people at different levels of need. In the future, we want a means-tested system that encourages people to plan and save for the future. Ideally, the system should also support people in achieving the outcomes they want – with them making choices about their care based on what is right for them.

When responding to our Call for Evidence and in our deliberative research, many people told us that they were particularly concerned about how the means test works for those in residential care. The £23,250 upper asset threshold for state support in residential care was seen to be particularly unfair. We agree that the level at which the threshold is currently set is not fair or sensible. **We therefore recommend that the upper threshold within the residential care means test should be raised from £23,250 to £100,000.** This will mean that more people are eligible for state support and will offer greater protection to homeowners, in particular those of more modest means whose savings have been accumulated in their home.

Aisha

An example of how the reformed means test would work.

Aisha 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 the age of 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, Aisha had to use up 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. Some £22,000 out of her £78,000 of wealth was left.

Under our reformed system

Aisha's 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 p.a. and so 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 only contribute towards her general living costs. She would be able to keep £62,000 of her assets.

Chapter 3: The rationale for our model

Capping risks

Protecting people from high care costs benefits everyone

Everybody currently faces a high degree of uncertainty over the future costs of social care. At present, neither the state nor the private sector offers people the chance to protect themselves against these potentially very high costs. People are faced with a very significant risk that they can do little to avoid or mitigate.

Given this, our recommended approach is that individuals should take responsibility for their own costs up to a certain point but, after this point, the state should pay. We see our proposals as a type of social insurance policy, with an ‘excess’ that people will need to cover themselves. We are proposing that risks are pooled, so that the cost of an individual with very high care needs is shared across the population.

During the course of our work, we looked at a range of different approaches to pooling risks so that people have protection against high care costs.

Firstly, we looked to see whether this was something that could be left to the private sector – as with areas such as house and car insurance. The problem is that there is currently too much uncertainty involved for the private sector to take on the full risk. There is uncertainty over how long people will live, uncertainty over changing care and support needs, uncertainty over costs, and uncertainty over wider changes that could affect care (such as medical advances or changes to the economy). These uncertainties have meant that the sector has struggled to design affordable and attractive products that people want to buy. No country in the world relies solely on private insurance for funding the whole cost of social care.

We also examined the case for a full social insurance scheme. This would provide everyone with full protection from care costs. However, it would require a much larger increase in public expenditure than our proposals, and would leave little scope for future flexibility in costs. Evidence suggests that those countries that have introduced full social insurance schemes have cut back on care packages and eligibility in response to fiscal pressures. The consequence of this is that unmet need is rising and people are still left exposed to very high care costs. We are very keen that any new scheme should be resilient to changes in the economic, political or social environment.

Given this, we decided that a shared responsibility model was best because risks are shared between the state and the individual. There are several different approaches to sharing the risk, but we believe that capping overall costs offers the best way of providing protection against very high costs – the costs that people really worry about.

The benefits of risk pooling¹³

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

Assume that 25% of people over 65 years of age need intensive care and support, costing £30,000 a year, for an average of two 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 costs of the maximum potential duration of long-term care. Working on figures of £30,000 p.a. for 20 years, this would equate to £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 two years, at £30,000 p.a. with a probability of 25%. In total, this would mean spending £15,000 (excluding administration costs).

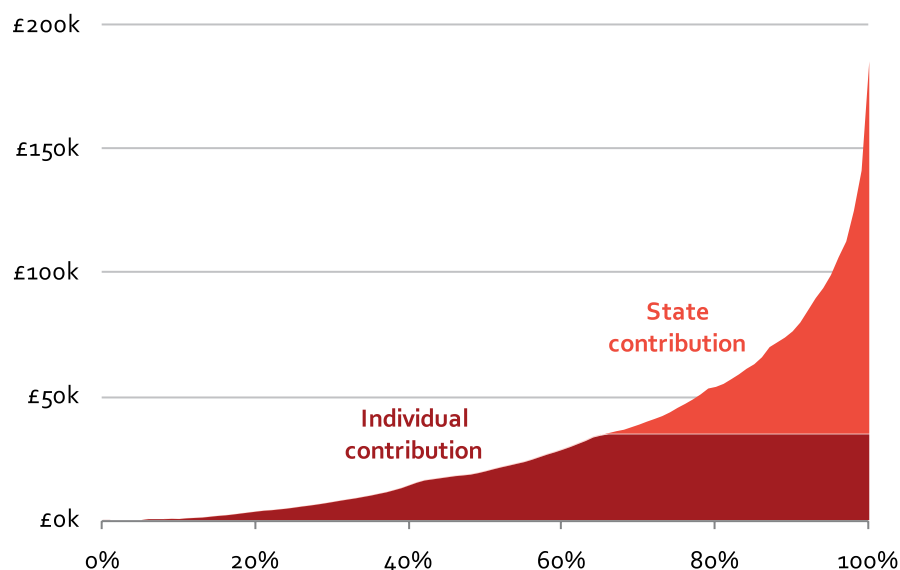
With risk pooling in place, people who wanted to protect themselves would not have to save £600,000; instead they would pay an insurance premium of £15,000.

The benefits of capping the cost

By capping the costs that individuals face, we are introducing partial risk pooling for high care costs. The reforms target resources on those with the highest needs, but give greater peace of mind to everyone.

¹³ Example adapted from ‘Long term care: a suitable case for social insurance’, Barr N, *Social Policy and Administration*, 2010; 44(4): 359–374.

Figure 6: Lifetime care costs met by the individual and the state under a £35,000 cap, for people entering care, by percentile¹⁴



Source: ESHCRU/PSSRU microsimulation model

A minority of people would face costs above the level at which the state steps in. We believe that setting the cap at around £35,000 would mean around a third of all people entering care (or a quarter of those aged 65 now) would reach the cap. These people would be those with the highest care needs over the course of their lifetime.

Everyone would benefit from knowing that if they ended up in the position of facing these costs, they would be covered. We would remove the fear and uncertainty of the current system, which should encourage people to make sensible preparations and to save. There would also be new space for financial products, which could support people in making their individual contribution.

Figure 6 shows the distribution of costs of care for those entering care in 2009/10 – and the costs that would be borne by the state and individuals under our proposals. The profile of this risk – with most people facing manageable costs, but an unlucky few facing high costs – is similar to other risks against which we usually insure.

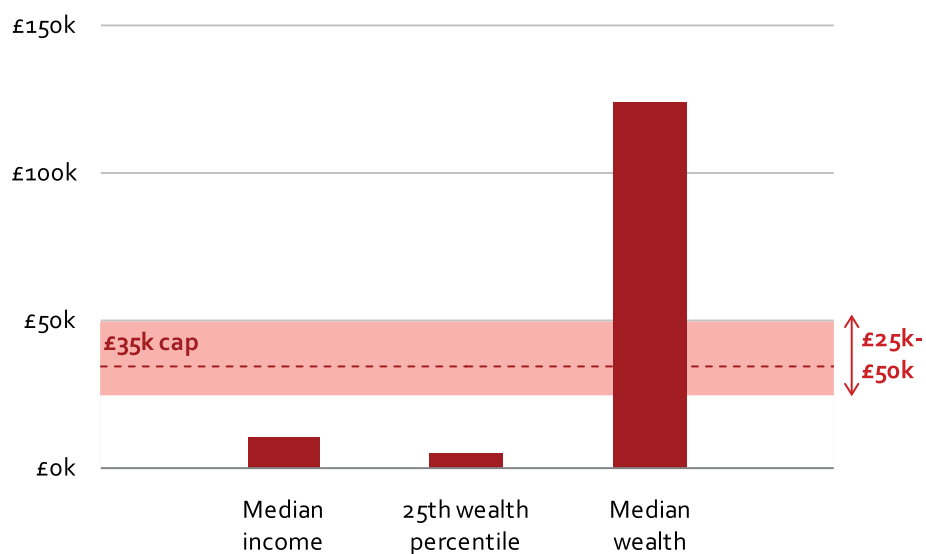
¹⁴ This chart looks only at people who enter care, ignoring the quarter of 65-year-olds who can expect to need little or no formal care. The effect of the means test is not shown – in practice many people would receive additional help in making their contribution. Costs are adjusted for care cost inflation and presented in 2009/10 care prices, to reflect the effect of a cap that rises in line with care costs.

The level of the cap

We believe that the cap should be set at between £25,000 and £50,000. We have used a figure of £35,000 throughout this report to illustrate the impact of the cap, as we think this is a realistic contribution for many older people. To put this in context, the median property and savings wealth of single women aged 75–84 is £124,000, with a quarter of this group having assets of less than £5,000.¹⁵

It is possible that the cap could be set at a different level – either a little higher or lower. However, we do not think it should be set in excess of £50,000 or below £25,000. Anything above £50,000 could mean people with lower incomes and lower wealth would not receive adequate protection; anything below £25,000 would suffer the same drawbacks as full social insurance, jeopardising our principles of sustainability and resilience. In our view, moving outside the range of £25,000 to £50,000 could mean that the overall reforms would fail to satisfy our criteria on fairness and sustainability.

Figure 7: The cap compared with typical levels of wealth and income for single women aged 75–84 in England



Sources: Wealth and Assets Survey; DWP Pensioners' Incomes Series

Earlier in the report, we outlined our proposal that the cap be tiered for younger people, to take into account differentials in the likely ability to accumulate assets. We have proposed that all those who reach adulthood with an eligible care and support need or who develop one before a defined age should have their cap set at zero. We have suggested that this age is 40, after which the cap would increase in incremental steps up to retirement age.

¹⁵ Wealth and Assets Survey 2006–08, ONS.

The level of the cap is discussed further in the evidence and analysis supplement to our report.

General living cost contribution

People living at home have to pay general living costs such as food, heating and accommodation. After reaching the cap on care costs, we think it is right that people continue to do this. If they are receiving care while living at home this happens automatically. If they need to move to a residential care facility, we think the general living costs contribution should be at a level that is both affordable and representative of general living costs.

The Guarantee Credit guarantees a minimum income of £7,142 for those over state retirement age. The median net income of single people aged over 65 is £11,284,¹⁶ which, after subtracting the Personal Expenses Allowance (PEA),¹⁷ means that around half of older people should be able to afford a contribution of £10,000 out of their incomes. Given this, we have suggested a contribution towards general living costs in the range between £7,000 and £10,000 p.a.

Setting the level of the contribution will be a decision for the Government. In doing so, it will need to balance this contribution against the overall level of the cap. The Government will also need to consider the level of the contribution of people of different ages – and the appropriate level of contribution for those of working age who are likely to have lower incomes.

Raising the threshold for state support in residential care

Means-tested support must continue for those who need care and cannot afford to contribute up to the cap. To support people effectively, however, the current means-tested system needs to be improved. It has grown up piecemeal over time and there are many inconsistencies.

The current residential care means-tested system does not give any support to those with assets over £23,250 – including housing assets. For people with assets below £23,250, the means test makes a judgement about how much they can afford to pay. Anyone with assets below £14,250 is only asked to contribute from their income. Those with assets between £14,250 and £23,250 are assumed to be able to make a contribution from their assets of £1 per week for every £250 of assets that

¹⁶ Source: Pensioners' Incomes Series 2009/10, Department for Work and Pensions.

¹⁷ The amount that, in assessing a resident's ability to pay for his or her care home place, the local authority is required to ensure is retained for personal expenses; this is currently set at £1,175 p.a.

they have above the £14,250 minimum (known as tariff income). If a person's care costs are greater than the amount they can afford, the state pays the difference.

The withdrawal of all support at £23,250 means that the means test offers virtually no protection to homeowners who need residential care. Median housing wealth among single people over 65 who own property is around £160,000, so most homeowners would have to spend nearly all of their housing assets before qualifying for support. We are therefore recommending that the threshold should be increased to £100,000, with tariff income calculated on assets between £14,250 and £100,000 so that more people receive some state support. This would mean there is greater protection for homeowners than at present.

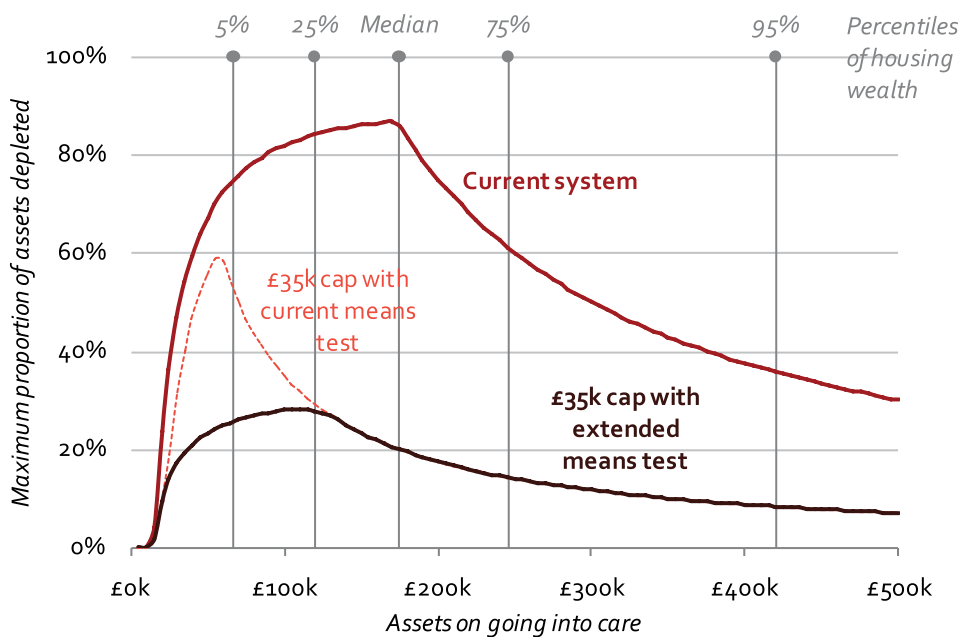
Interaction between the cap and the means-test threshold

The capped cost model sets the maximum contribution that anyone will need to make towards their care costs over their lifetime. For those who are less able to afford this contribution, the means test ensures that the state helps them so they will not have to pay the full amount.

However, means-tested support is currently withdrawn sharply if someone exceeds the asset threshold of £23,250. If a cap of £35,000 were applied together with the current means test, this would mean that almost all homeowners would pay the full costs of residential care until they reached the cap. As shown in Figure 8, 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 compared with the current system, in which people can lose almost 90% of their assets in paying for care. However, the impact is still felt disproportionately by those in the lowest wealth quartile.

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 8: Maximum possible asset depletion for people who enter residential care and have lifetime care costs of £150,000¹⁸



Source: Commission analysis, Wealth and Assets Survey

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.

Chapter 4: Making the system work for people

Supporting people in meeting their contribution

Universal disability benefits

Under our reforms, universal disability benefits for both older people and working-age adults will continue. **We are not proposing any reforms that would result in anyone losing their disability benefits.** We understand that people appreciate cash benefits as this enables choice and control, and supports them in living independent lives.

For older people, there will continue to be a universal disability benefit to support those with care and support needs. This should support people faced with additional costs, encourage early intervention and help people who rely on unpaid care to meet their care needs.

The benefit will look like the current Attendance Allowance (AA), but to facilitate the move towards a clearer, national offer, we recommend that:

- The Government should clarify the role of AA by re-branding the benefit. People do not understand the term ‘Attendance Allowance’ or the purpose of the benefit. We know that many people who are eligible for AA are not currently claiming it. Research conducted by the Institute for Fiscal Studies suggests the name of a benefit can have a real effect on how it is spent.¹⁹
- People who reach the cap and start to receive free state-funded residential care should not receive AA in addition to the care package as this would mean the state paying twice for the same need. This would also mean that those benefitting from the cap are treated in the same way as those receiving means-tested support.
- The Government should consider how to align the assessment for disability benefits with the adult social care system. We discuss elsewhere in this report the need for a more objective, national assessment scale for social care. There is the potential for this new scale to complement the disability benefits assessment so that people experience a more aligned, simple and streamlined process.²⁰

19 *Cash by any other name? Evidence on labelling from the Winter Fuel Allowance*, Beatty TKM, Blow L, Crossley TF and O’Dea C, Institute for Fiscal Studies working paper 10/11, 2011.

20 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.

For younger adults, the Government has already announced a reform of Disability Living Allowance (DLA) and the introduction of the Personal Independence Payment (PIP). Eligibility for PIP is based on an independent assessment including a face-to-face consultation. Given these changes, the Commission is not proposing any further changes 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.

Financial services products

At the moment, no major financial services providers offer pre-funded insurance against social care costs. This means people are not able to protect themselves in advance of having a care need. There are some specific products that can help people, and are taken out, when they already have a care need, such as equity release and immediate-needs annuities.²¹

There are complex reasons for the lack of pre-funded insurance policies. Partly it is because it is very difficult to price an insurance contract – the time periods are long and the risks are very uncertain. Partly it is because people do not currently want to buy the products. The reasons for this lack of demand include: a lack of understanding about the current system; a belief that care is free, like the NHS; a reluctance to address something unpleasant to think about; and, for some, a preference for taking a risk, rather than trying to save for a cost that they are unable to predict and that could be potentially very high.

We have had extensive discussions with the financial services sector and think that our proposals would stimulate both supply and demand. By capping the overall risk that people face, new financial products could develop to support people in making their contribution. These products could be linked to pensions, savings, insurance and housing. Our view is that given the tax-favoured treatment of pensions, ISAs, and housing, these are most likely to be the vehicles used to prepare for social care costs.

²¹ Immediate-needs annuities are purchased as a lump sum when someone needs care. They then 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.

What types of financial products may emerge?

A variety of different products may emerge, taking into account the needs of different segments of the market, supporting those of different ages and income levels. The industry has indicated that possible products include:

Products linked to pensions – disability linked annuities could become an attractive product in the future. A disability linked annuity works 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) or reaching a certain age (e.g. 85). **Clarifying the tax treatment of disability linked annuities could further encourage activity in this space and we recommend that the Government make a clear statement that disability linked annuities are permissible under current pension taxation rules.**

Products linked to housing assets – we think many people may decide to use a part of their housing wealth to meet their contribution. To release housing equity, some people may decide to downsize, others to take out an interest-only loan secured on their 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 said that there may be opportunities to convert critical illness cover or life insurance policies to offer cover for care costs. A further insurance area that could potentially grow is top-up insurance, which could provide an extra amount of money to supplement the amount people spend on accommodation and general living.

In order to support the development of the market, **we recommend that the Government should set up a working group** of central government, local government, the financial services industry, the Financial Services Authority and interested third-sector organisations to consider how to enable the development of an effective market and support consumers in making sound choices.

Deferred payments

We recommend that the Government consider changes to the current deferred payments scheme as this is a mechanism for helping people release funds from housing assets. With a deferred payment, local authorities agree to pay in advance for care if individuals cannot afford to do so without selling their home; it then recoups the money when the house is sold.

Evidence submitted to the Commission suggests that the availability and use of deferred payment schemes is patchy. Local authorities do not have to offer deferred payments, although they are encouraged to do so. Local authorities are also not currently able to charge interest on the loan and therefore running the scheme has a cost to them.

At a minimum, the Commission recommends an extension to the current deferred payment scheme so that it is a full, universal offer across the country. Anyone who would be unable to afford care charges without selling their home should be able to take out a deferred payment. In making this change, we believe it would be sensible for local authorities to be allowed to charge interest to recover their costs, to make the scheme cost neutral, and to remove the disincentive they currently face in promoting the scheme. The Government may decide that it wishes to extend the deferred payment offer further so more people could benefit from the scheme.

It is for the Government to consider the best way to strengthen and standardise the deferred payment scheme, in light of the decisions it makes on the level of cap, means testing and the contribution to general living costs.

Helping people to prepare

Planning ahead

There is very poor understanding of how the adult social care system currently works and how much it can potentially cost. Many people live under the false impression that social care will be free if they need it. If people are confused over how the system works and the costs that they potentially face, they will not prepare appropriately for the future. This can lead to families having to make difficult decisions at a time of crisis.

For people to have choices, they will need to plan – and they will need to be supported to do so. Those who have benefitted from the opportunity of having a full working life should be able to plan ahead. We understand that those who are born with a disability or who develop a care and support need during their working life may be less able to prepare.

A new awareness campaign

Our reforms will help people to plan 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 undertake a new awareness campaign on the cost of care and support and the new funding system.**

In addition to changes to the social care system, we believe there are wider barriers to saving that need to be tackled. We know that the Government and financial services industry are already trying to get more people to save into pensions. In the future, we urge the Government to consider encouraging saving for social care as part of this wider agenda to encourage savings for retirement. It may be that some of the same levers and incentives can be used to change behaviour. We need to encourage people to think about how they would meet any social care needs they face in later life and ensure that they have sufficient resources and knowledge to achieve the lifestyle they want.

Better information and advice

To support our proposals, the Commission strongly recommends that the Government should develop a new information and advice strategy – one that both provides trustworthy basic information and signposts people to further advice. Basic information on how the system works and its relationship to benefits and financial products should be provided nationally. Access to more tailored information should be available locally, with local government taking responsibility for signposting people to reliable services and advice, irrespective of whether their care is funded by the state or not. Particular attention should be paid to meeting carers' needs for better information and advice.

In order to develop information and advice that really meets the needs of users, the Commission recommends that the Government should co-produce a new strategy with third-sector organisations and other interested parties such as the Financial Services Authority and local government. Different groups would bring different experience, knowledge and expertise, and help ensure that all of people's information and advice needs are covered.

Consistent national information

Underpinning any reforms will need to be a better provision of basic, factual information at the national level. This is probably best done through a new website that brings together in one place all relevant information and signposts people to additional support. This should cover a range of issues, including:

- how the overall care and support system works – the different components, and eligibility for each;
- signposting to more specific advice that is tailored to an individual's need, at the local level;
- support for carers and sources of advice;
- financial information with direction to where further advice can be found – particularly 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.

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 they are accessing is reliable and can be trusted.

Local information and advice for all

In the future, we believe that information and advice must be a universal service offered by all local authorities. Advice should be available to all, including those fully funding their own care. It should be the role of local authorities to make provision so everyone within their local community can get the information and advice they need. **Given this, we strongly support the Law Commission's proposals²² 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.**

²² *Adult Social Care*, Law Commission, 2011.

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 they want. Local authorities will continue to have a role in shaping the local market and this must include making sure people are aware of the services that are on offer.

We also recognise the role played by different voluntary groups – be those physical or virtual, formal or informal – in supporting individuals and carers. It is not the Government's role to provide this type of support, nor would it be advisable for it to do so, but people should be directed to such support, if appropriate.

Financial information and advice

Through our Call for Evidence, many told us that a lack of appropriate financial advice was a real problem within the current system. A lack of information on different financial options and products may be causing many people to make poor financial decisions at what can be a very distressing time.

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. The new Money Advice Service already has information on planning for retirement and long-term care costs; we recommend that this information should be enhanced and effectively signposted from other sources. We also recommend that local authorities encourage people to seek appropriate and reliable financial advice if appropriate – either when approached for information about care and support services or when an assessment is completed.

A clear, national offer

Improving assessment

Under the current system, each local authority can decide the level at which people are entitled to state support. Assessment processes are different and charging practices vary.²³ There are in effect 152 different systems across England – one for each local authority in England.

The result of such local variability is that people in very similar circumstances, with similar levels of need and financial resources, can be treated very differently and experience vastly different outcomes. Access to social care is often labelled a ‘postcode lottery’ and is seen as unfair. The level of variability adds complexity and leads many to be confused about how the system works.

Local variability also means people are unable to take their assessments with them should they move and their local authority changes. Individuals and families must go through a new assessment process and there is no guarantee that they will receive the same level of care. Worse still, transitional arrangements between local authorities are poor, meaning people are not even able to take their current assessment with them and use it until the new local authority completes their assessment. People are, effectively, trapped. This is detrimental to individuals’ well-being as it may prevent them moving to a new area – to work (or for a family member to work), to move to more appropriate accommodation, or to move to be nearer to their carer.

We want this to change. **We think that there should be a clearer, more objective eligibility framework and portable assessments.** The Law Commission has recommended that there should be a clear and consistent assessment and eligibility process and that assessments should be portable.²⁴ We strongly support these proposals, which will ensure compatibility with our proposals for changing the funding system.

Clearer and more consistent eligibility criteria

For our proposals to be the basis of a clear, national offer we think that eligibility for social care should be set nationally. The capped cost offer could work with the current assessment process for a time. However, a single eligibility threshold and more consistent eligibility criteria would make for a clearer, fairer and more coherent system for the public.

²³ Currently local authorities have to follow national regulation on charging policy; for domiciliary care, local authorities are able to design their own charging policies within national guidance.

²⁴ *Adult Social Care*, The Law Commission, 2011.

We believe that everyone, wherever they live in the country, should expect to start receiving state support when their care and support needs reach the same point.

It is for the Government to determine the precise eligibility threshold and criteria. **Our recommendation is that, until the current assessment system is replaced, the threshold should, at a minimum, be set at substantial.**²⁵ Anything higher than this would be unacceptable and would not be an effective way of managing care overall across the whole care and support system. The corollary of this is that the support in the means-tested system must also start at this level.

Transparent, portable assessments

Currently, local authorities use FACS²⁶ guidance to determine eligibility. This could continue in the shorter term as a basis for setting some form of national eligibility. However, we do not think that it is suitable for a sustainable, long-term settlement. We consider that the future system should have a new, more objective assessment scale, with a simplified and clearer process.

We understand that FACS takes into account a wide variety of factors and needs, but we think that the scale lacks transparency – people are not able to work out where, approximately, they may fit on the scale and whether they are eligible for state support.

The Commission recommends that the Government should develop a new assessment measure with experts in the field. This should be more objective and more easily understood, and people should be able to self-assess against the scale.

A new scale will also need to ensure it covers 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. Any new assessment scale will need to ensure that all of these areas are fully captured.

In developing any new assessment measure, the Government should consider:

- how any new system could be focused on helping people meet the outcomes they want to meet, and could put people in control of their care;

²⁵ ‘Substantial’ refers to one level of the FACS guidance.

²⁶ FACS was officially replaced by *Prioritising need in the context of Putting People First* in 2010; however, the system is still commonly referred to as FACS. Given this, we are continuing to use the term FACS in our report.

- how any new assessment process for social care could align with that of disability benefits for older people²⁷ so that people can understand how, as their needs intensify, support from the state increases; and
- how assessment processes in health, social care and benefits could be more consistent and compatible with each other. For example, sharing information between different professionals and practitioners has the potential to avoid duplication and deliver more joined-up care and support services.

The Government may wish to consult with the financial services sector on the development of any new assessment scale. If the financial services sector feels able to use the same scale as local authorities as the basis of its contracts, it has the potential to simplify the system further. Using a common scale could also add to public confidence in any new financial services products.

Many people have said that assessments must also be fully portable. People need to be able to move to a new area, free of the fear that they may lose the access to care and support for which they have already been assessed as eligible. This is important not only for the person who is receiving care, but also for carers.

Under the current system, individuals moving across local authority boundaries would lose their support until they were reassessed. This leaves some people unable to relocate – and many more worrying about the impact of moving, should they do so. Such restrictions curtail choice and work against the wider agenda of putting people in control of their care so they can control their own personal outcomes. It is clearly unacceptable.

Under our reforms, we want anyone moving from one local authority to another to retain their needs assessment until the new local authority reassesses that individual. The receiving local authority should have a duty to meet all eligible care needs in the intervening period. However, this would not mean that the care package itself would be fully portable – the level and type of support that an individual receives under different local authorities could still vary.

²⁷ For people of working age, the Government has already signalled its intention to change the assessment scale for the PIP. While the Commission does not want to cause further upheaval in this area, we do suggest that the Department for Work and Pensions considers how the PIP and the reformed social care funding system can be aligned.

Thomas

An example of someone with a care and support need moving to a new area.

Thomas's wife died and he was left living in a large semi-detached house in Manchester on his own. He became increasingly frail over time and, at the age of 80, he was assessed as having a 'substantial' care need by his local authority. His son became increasingly worried that his father was not coping very well living on his own and might fall and hurt himself. Thomas therefore agreed to move to a smaller flat in Southampton to be near to his son.

Under the current system

Thomas would not be able to take his assessment with him. He would need to move to his new local authority and then be reassessed. Before he was reassessed, he would not be eligible to receive care from his new local authority. If his new local authority had set its eligibility threshold at 'critical' he might also lose his state support.

Under our reformed system

Under our reforms, Thomas would be able to take his assessment with him, and his new local authority would have to continue to provide that care up to the point at which they could reassess Thomas and decide on his new care package. As eligibility thresholds would be set nationally, Thomas would be guaranteed to continue to receive support, although the type and level of support that he received might change to take his new circumstances into account.

Thomas's care package would also be counting towards his cap of £35,000. His existing contribution would transfer to his new local authority – he would not need to start his contribution again.

Local responsibilities

Under our proposals, local authorities will continue to play a central role in ensuring the delivery 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.

Local authorities would continue to assess people presenting with a care need, and assign personal budgets or direct payments to help people meet these needs. For those eligible under the means-tested system (and, in future, those reaching the cap), local authorities would continue to fund their care packages; for people funding the care themselves, local authorities would assign notional care packages.

Local authorities would also continue to commission (and support those with direct payments to commission services directly), and in some cases provide, a range of services to support their local population, irrespective of their means. Examples of such services include community meal services, telecare and information services.

We are aware of the need to balance a more national offer with local flexibility. Flexibility is important for two reasons – firstly, for financial management and, secondly, for service delivery. We think it is important for the Government to ensure sustainable funding for local authorities so that they are able to manage the existing pressures as well as the new requirements as a result of our reforms; and it is important that money made available centrally for adult social care is used for that purpose locally.

Financial management

Local authorities will remain responsible for the overall social care budget and will need to be able to manage overall costs. In order to do this, they will be able to determine the cost of care packages, at local prices, within the system. They will also continue to decide how best to allocate budgets across different services and levels of need – for example, how to balance investment in early intervention and supporting those with higher level needs.

Service delivery

Although we feel strongly that the overall funding system should be a national offer, we believe local authorities to be the best judges of how best to meet the needs of their local populations. What works well in inner London is unlikely to be appropriate in rural Cumbria.

Local areas differ in the configuration of their services and their historic provision; some have large numbers of residential care homes places, while others have focused on domiciliary care. The role played by third-sector organisations, social enterprises and voluntary services also differs across the country. We know that these organisations often work closely with local authorities and health bodies in order to deliver appropriate and effective support services to the local community.

Given this, we believe the delivery of social care is best commissioned and delivered at the local level. Local authorities are held accountable by their local populations for the services they deliver, and can take a strategic approach to the delivery of services. They are best placed to match service provision to the needs of their local population, to support individuals in purchasing the services they want, to ensure high quality provision, and to shape the overall market. However, in undertaking this work, we believe local authorities should work with colleagues in the NHS and public health. The best local authorities will also seek to engage fully with the community in designing and planning services.

Personalisation

All our proposals are consistent with personalisation. We want people to have choice and control over their care and support so that they can meet the outcomes that they want. Care packages and support should continue to be delivered via personal and direct payments under our proposals.

Quality

It is our expectation that our reforms will be an important step in delivering higher quality services overall. Our proposals should lead to a better resourced system, in which people are less fearful of the future, feel able to spend their money more effectively and can manage their care as best suits them.

During the course of our work, many people raised issues about the delivery and quality of care provision. For example, there are complex issues around workforce, the residential care home sector, 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 its provision. The Government has already outlined its policy direction in its vision for adult social care²⁸ and through the work on developing a quality framework for social care.²⁹

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 design personalised packages, it is necessary for there to be a range of high quality services. This does mean, however, that the sector has to remain adequately funded.

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

28 *A Vision for Adult Social Care: Capable communities and active citizens*, Department of Health, 2010.

29 *Transparency in Outcomes: A framework for quality in adult social care*, Department of Health, 2011.

Recognising the contribution of carers

Carers are the foundation of the care and support system, and will continue to be so in the future. The contribution of carers complements that of formal care services; as such, there needs to be a care and support system that actively engages with, and supports, carers. In designing a new funding system, we have been mindful of the need to recognise their valuable role within the care and support system and to support them in continuing to play this role.

Around five million people have some caring responsibilities, with approximately one million people caring for over 50 hours a week. Every carer is different, and has different needs and aspirations. Caring is a rewarding and positive experience for many, but some people's caring responsibilities can become detrimental to their own health and well-being. According to the latest large-scale survey of carers, around half (52%) said their health had been affected because of the care they provide.³⁰ Some also face financial hardship because they feel forced to leave paid work.³¹ We recognise that insufficient support for carers is counterproductive for individuals, families and society more widely.

From the outset of our work, we have been clear that any future adult social care system would 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 there is scope to improve the system for carers significantly through our reforms.

Over the course of our work, we have spoken to carers and their representative organisations to understand how better to support carers. Three particular issues were raised consistently – improved carers' assessments, better information and advice, and support to work. We agree that all these areas are important and need to be improved.

³⁰ *Survey of Carers in Households – 2009/10*, The Information Centre, 2010. www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/survey-of-carers-in-households—2009-10-england.

³¹ 41% of carers state that they have financial difficulties in the *Survey of Adult Carers in England – 2009-10, Personal Social Services*, 2010. www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/personal-social-services-survey-of-adult-carers-in-england—2009-10.

A better funded system is better for carers

We believe that our overarching funding proposals will, as well as improving the system for those with a care need, also offer carers greater support.

- Firstly, our recommended reforms should lead to a better resourced system overall. Greater resources being devoted to social care overall should drive up the quality of services and reduce the burden on carers. Evidence suggests that better services for the cared for bring real benefits to carers.³²
- Secondly, providing fully state-funded care for those people who have very intensive needs, or who have had a care and support need for a long time, should lessen the responsibilities that some carers currently face over the course of their lifetime.
- Thirdly, our recommendations for a national eligibility and assessment framework, with portability of assessments for the cared for and carers, and for improved information and advice, should offer greater support and clarity to families. Many people have told us that they did not want to be a burden on their spouse or children in later life. Under our system, we hope that people will be able to plan ahead and make better provision.

The support already provided by the Government should continue, including targeted respite care and cash support, Carer's Allowance and National Insurance credits.

Improved assessments and services for carers

To support carers in the contribution that 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 the impact of caring is manageable and sustainable.

As now, we believe that any reformed system will need to continue to be 'carer sighted' (that is, the contribution of carers is taken into account when deciding on the appropriate pack of support). However, we think it is important that carers are fully consulted about what is a reasonable contribution and any specific support that they need. We believe that any system should ensure that the demands placed upon carers are not too great and that the needs of the carer (e.g. in relation to work (paid or unpaid), leisure and education) should be taken into account.

The Law Commission has proposed that carers should have new legal rights to services.³³ Under their proposals there would be a new social

³² *What are the most effective and cost-effective services for informal carers of older people?* Pickard L, Research in Practice for Adults, 2006.

³³ *Adult Social Care*, Law Commission, 2011.

care statute that would set out a single and standalone duty for local authorities to undertake a carer's assessment. Local authorities would need to decide on whether to provide services against a national eligibility framework for services for carers and would then be required to meet the eligible needs of carers by providing services to either the cared-for person or the carer.

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 reaffirmed in the 2010 update to the strategy).³⁴ These are that carers:

- be respected as expert care partners, so that a carer's contribution is fully valued;
- be treated with dignity and respect;
- 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;
- 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 a whole-family approach is taken, for the benefit of both the individual who needs support and those who are supporting them. Allowing all parties in the partnership to identify their own needs and desired outcomes is beneficial to the well-being of all concerned and is likely to lead to care that 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.

It can take many weeks before a carer's assessment is completed, and then nothing can come of it. **We recommend that, in the future, assessments of carers and individuals happen at the same time, but are completed separately, to make sure carers feel able to speak openly**

³⁴ *Carers at the Heart of 21st-century Families and Communities*, HM Government, 2008, and the strategy's refresh in 2010.

about their needs. Assessment should also be repeated regularly; 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.**

Better information and advice

In gathering views and evidence, we have heard that carers struggle to find out about the support available to them because of a lack of good information and advice. Carers can be making significant financial decisions, and without proper advice they may not always make the best choices. For example, if a carer was aware of the options around home care, it might be possible to avoid having to move the person they are caring for into much more expensive residential care. We also know that, even where information is available, people sometimes need help interpreting it and advice on the best way forward.

Carers and their representative organisations have called for much improved information and advice. In light of this, **we are recommending that 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 that can provide support – both as they begin to care and at all stages of the caring pathway. In particular, we think GPs should ensure that they are mindful of the effects that caring can have on someone’s health and seek to ensure appropriate support is in place.

Caring and working

Carers make a valuable contribution to the economy. We want to enable them to undertake paid and unpaid work, should they want to. Forcing people out of the labour market is not only bad for those who are caring, but can also negatively affect those for whom they care; balancing work with caring, however, can be very difficult.³⁵

³⁵ *‘Help wanted? Providing and paying for long-term care’*, OECD, 2011. The OECD has found that in Australia and the UK informal caring is associated with a higher probability of both stopping work and switching to part-time work, although the report also highlighted that the UK had flexible working arrangements that appeared to be somewhat effective in supporting carers. Evidence suggests that, 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.

Among carers who are of working age in England, 26% feel that their caring responsibilities have affected their ability to take up or stay in employment;³⁶ one in six carers have given up work or reduced their hours of work to care.³⁷

We encourage the Government to push forward with efforts to encourage and support carers to work. However, we also believe that it is in an employer's interest to be flexible when considering the needs of someone with caring roles. As a society, we have made great strides when looking at how to support those with children to work; we now need to think how we can do the same for carers.

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. As an example, many may be unaware of their legal right to request flexible working arrangements.³⁸

³⁶ *Survey of Carers in Households – 2009/10*, The Information Centre, www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/survey-of-carers-in-households—2009-10-england.

³⁷ Research by Ipsos MORI for Carers Rights Day, December 2009.

³⁸ Evidence from the Standing Commission on Carers to the Commission, June 2011.

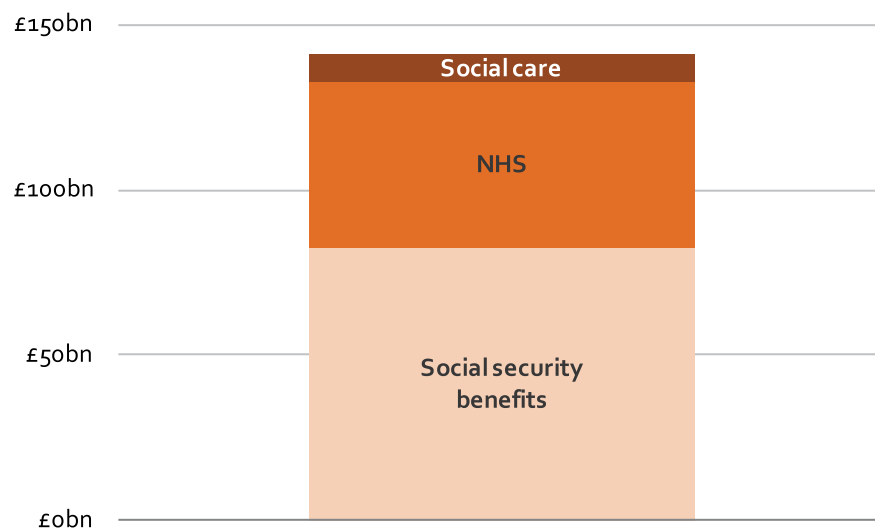
Chapter 5: The wider care and support system

Boundaries between services

When someone has a care and support need, they can be unsure about which part of the state funds the services they need. We know there are many different state services, delivered at the national and local level. For example, the NHS, the adult social care system, social security benefits, public health services and housing services all provide support. The problem is that all these elements overlap and interact – sometimes positively, but sometimes negatively. When services work well together and are shaped around people, outcomes are better; when they do not, people experience disjointed services and their experiences are poor.

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 9: Estimated public expenditure on older people in England 2009/10



Sources: Department of Health; Department for Work and Pensions; Commission analysis

Looking to the future, the Commission urges the Government to consider how the different streams can be brought together better in the interest of individuals and carers.

Aligning funding

The problem with having different funding streams is that care and support needs cannot easily be divided up to match these funding streams and artificial boundaries are created. Care and support needs lie on a spectrum – people might try to define the roles and responsibilities of each part of the system but, in reality, they overlap.

We recognise that, while there are different funding mechanisms in place, it will be impossible to remove all these boundaries. For example, by having a free at the point of need health service, but a shared responsibility social care system, difficult decisions on funding will have to continue to be made. We want a system that is more consistent, with less variability, and one in which people feel that services are working for them, not against them.

Improving the social care and NHS boundary

Given the significant overlap between health and social care provision, the different funding streams can sometimes be a barrier. There are examples of where the consequences of having different funding streams can seem very unfair to people, as is the case for NHS Continuing Healthcare, and there are cases where funding mechanisms can get in the way of delivering appropriate care and support, such as at the end of life. Where funding streams have been integrated, or a more co-ordinated approach taken, there is evidence of improved outcomes, high quality services and better value for money.

NHS Continuing Healthcare

One of the most acute examples of this funding boundary issue is NHS Continuing Healthcare, which provides critical support for many people with high health needs. Many of these people also have high social care needs. NHS Continuing Healthcare is defined as care provided over an extended period of time to meet physical or mental health needs that have arisen as a result of disability, accident or illness.

Those assessed as eligible for NHS Continuing Healthcare receive all their care free at the point of need; however, those who narrowly miss out, but still have a high level of care needs, may need to pay for all of their care themselves (although may benefit from NHS-funded nursing care). Under our proposals, this cliff edge does not disappear but it does become less threatening because the costs that people face are capped.

We are strongly supportive of the Law Commission's recommendation to put NHS Continuing Healthcare on a firmer statutory footing.

Furthermore, as we are recommending a new national eligibility framework for social care, which is aimed at being more transparent and consistent, the Government may want to consider how this will work alongside the assessment process for NHS Continuing Healthcare. Clarity in this area could be beneficial to many.

Re-ablement

Re-ablement packages support people in learning, or re-learning and practising, skills for daily living such as washing and dressing so that they can live independently for much longer. It is a good example of where

health and social care are taking a more co-ordinated approach and, as a result, are better supporting people and saving money. **We welcome the Government's commitment to re-ablement services that are free of charge and believe that this should continue in the future.**³⁹

End of life

For those reaching the end of their life, we think that there should be better integrated health and social care services, and that there is a strong case for these being free at the point of need. At this time, the last thing that individuals and families need is arguments over who funds care, and where care is provided. Given this, **the Commission is broadly supportive of the direction of travel being taken by the independent Palliative Care Funding Review, which is looking into the funding of end-of-life care.**⁴⁰

Integration of social care and the NHS

Successive Governments have tried to encourage integration of health and social care, and some progress has been made. **The current Government has signalled its support for greater co-operation and the Law Commission has put forward proposals to place duties on councils and the NHS to work together. We endorse this direction of travel.**

There are examples of good practice across the country. Some users of services, such as those with a mental health condition or with a learning disability, often experience a more joined-up health and care service. There are also some specific integrated services, such as crisis response and re-ablement. Some places have pooled budgets and there are examples of fully integrated care trusts.

But more needs to be done. We need to see these examples scaled up and replicated across the country. In particular, we are strongly supportive of moves towards properly pooled budgets. Having a single budget holder should lead to more strategic decisions on service delivery and reduce the number of unhelpful disputes between professionals.

Aligning benefits

We are recommending that universal disability benefits – based on the level of need, not means – continue. Earlier in the report, we outlined how we thought there should be a more streamlined approach to the assessment of the major disability benefits (AA and DLA) and social care. We also said that we thought there was a case for re-branding AA.

³⁹ The Government has committed to free re-ablement for people for the first six weeks, and after this local authorities will be able to raise charges. See www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_122167.pdf.

⁴⁰ For more information on the review see: <http://palliativecarefunding.org.uk/>.

In addition to AA and DLA, there are many other benefits, grants and funds that individuals or carers claim; examples include Carers' Allowance, Severe Disability Premium in Pension Credit, Disabled Facilities Grant and Supporting People. Interactions between these are complex, and the Commission recommends that the Government should undertake a full review of the effects of changes to the funding of the social care system on these benefits, grants and funds. **Where possible, the Commission urges the Government to consider how to simplify the system – through better alignment or integration of funding streams.**

Encouraging early action

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

The Commission agrees that increased prevention activities and earlier intervention is beneficial. Such activities have the potential to stop an individual's needs escalating, while delivering savings to the state. If people are able to plan and prepare better for the future costs they face, and know that there is an overall limit on what they will need to spend, we believe this should encourage greater investment at an earlier stage.

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. We are very supportive of this direction of travel. The Commission expects that local areas will put in place strategies for prevention and early intervention, and use future public health funding, to support 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.

Technology

In the future, we anticipate that there will be continuous and rapid technological advances that will have a significant impact on the way care and support is delivered. New technologies are already making their way into care and support – from sophisticated telecare equipment to more simple devices such as kettle slings. These technologies already have the power to transform the lives of individuals and carers, and more opportunities will open up in the future. We hope that, once people know there is a limit on how much they will need to spend on care, it will encourage individuals and families to invest in new technologies early, to improve quality of life and prevent needs from escalating.

Social care and housing

The Commission understands the critical role that housing provision plays in improving well-being and delivering better outcomes for individuals. Being housed in suitable accommodation can improve someone's overall quality of life by offering greater security, support and peace of mind. Specific support through aids, adaptations and home modifications can help people remain at home and manage needs better.

We know people are very attached to their family home and our proposals should support people in staying there for as long as they wish. However, sometimes more appropriate housing could bring significant benefits – some may find that downsizing or moving to a more suitable type of accommodation could improve their health and overall welfare. We want people to start planning earlier because this will allow them to exercise far greater control than if they wait until they develop a significant care and support need or face distressing and critical circumstances. For example, the Commission hopes that more people will be able to consider extra care housing in the future, if they are more aware of this type of provision and can be more certain over their financial planning.

Chapter 6: The impact of our proposals

Appraising our overall funding model against our criteria

In our Terms of Reference, the Government asked us to appraise our chosen funding model against a set of criteria. The table below provides a summary of this analysis. A full option appraisal is presented in our longer analytical report.

Figure 10: Appraising our funding model

Criteria	Our model
<p>Fairness</p>	<p>We think it is fair that responsibility is shared between the state and individuals, and that people who are in need of care now should make some contribution to their own care.</p> <p>With our funding model, support is targeted on those with the greatest need over their lifetime but everyone – individuals and carers – benefits from knowing that they are protected from very high costs. Raising the threshold for support in the residential care means test to £100,000 will also offer greater protection to those with lower housing assets.</p> <p>Our other reforms also pave the way for a fairer system. For example, a single national eligibility threshold and a more objective assessment system should reduce local variability. We are also supporting a fairer system for carers, through improved assessments.</p>

Criteria	Our model
<p>Choice</p>	<p>By limiting the costs that individuals can face, our proposed funding system gives people the chance to plan and prepare. People will only pay for the care they need and they will have a range of different ways to fund their contribution. The model also opens up a space for the financial services industry to provide products that give people even greater choice.</p> <p>A better information and advice service should support people in exercising this choice.</p> <p>Our reforms are fully consistent with personalisation and work with personal and direct payments. Universal disability benefits also continue in the current form, supporting people in independent living.</p>
<p>Value for money</p>	<p>By targeting support on those with the greatest lifetime need, this system uses money where it is needed the most.</p> <p>Our system also supports people in making decisions that are better for them financially.</p>
<p>Sustainability and resilience</p>	<p>Our model is flexible and adaptable in the longer term.</p> <p>Our system has a number of different elements (e.g. the level of the cap and the contribution to general living costs) that the Government can change over time, within reason, without undermining the overall system.</p>
<p>Ease of use and understanding</p>	<p>Under our reforms, people will have a clear figure to work towards – something that our deliberative research indicates people appreciate. There will be some additional administration as a result of moving to a wider offer.</p> <p>National eligibility thresholds and a more objective, simple assessment system (better aligned with other parts of the care and support network) should also simplify the overall system.</p> <p>We are also recommending a new awareness campaign, re-branding of AA, and improved information and advice to support people in understanding the system.</p>

Impact on different groups

We do not think any particular groups will be disadvantaged by the funding proposals we have set out in this report. Everyone who currently gets free care under the means-tested system will continue to do so, and everyone else benefits from our proposals.

One of the underpinning principles for reforming the funding system was that it should promote the well-being of individuals and families, enable people to maintain their dignity, protect those in vulnerable circumstances and help everyone participate in the wider community. We also believe that any reforms should respect an individual's human rights. We believe that our proposals for funding reform meet these principles. Our proposals are also fully consistent with the personalisation agenda and should support people in living independent lives.

In this section we look at the impact of our proposed funding model on different groups. However, there are other areas that will also have a positive effect for many people, including improved information and advice, national eligibility thresholds, and improved assessment processes and portability.

Our programme of deliberative research was designed to ensure that we took the needs of specific groups into account when coming up with our proposals. In our analytical report we provide a more detailed analysis; we summarise our main conclusions below. A full equalities analysis on the details of the proposals will be required when the Government takes forward funding reform.

Better support for everyone

We believe increasing the overall level of public expenditure should offer people greater access to care and support, and reduce unmet need.

Some people will benefit directly from our proposals by reaching the cap and receiving care free of charge from the state. We estimate that around a quarter of current 65-year-olds can expect to reach the cap. However, these are not the only people who benefit – with a cap in place, everyone will know that there is a limit on the amount that they will have to spend, reducing fear and anxiety and providing greater peace of mind.

We also believe that our proposals will encourage people to spend more on meeting their needs earlier. Encouraging people to plan and prepare should help people make better choices.

Impact on those using services

Under the current system people with the greatest care and support needs face the highest costs. The capped cost scheme targets resources on those with the highest needs over the course of their lifetime.

Most younger adults currently receiving their care without charge will be unaffected by the introduction of the cap. Some of those who are currently subjected to means-tested charges or are funding their own care will benefit from a cap on the costs that they face. Older people gain in two different ways – firstly through having care paid for if they should have high needs and, secondly, through the removal of the fear of having to potentially pay hundreds of thousands of pounds for care.

Carers will also benefit from extra resources going into services and better support for those for whom they care. Furthermore, our recommendations for a national eligibility framework and improved assessment processes should offer greater clarity and flexibility to families as a whole.

Disability and specific conditions

We know that those who have a disability throughout their life on average 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. Our proposals will support people who are disabled by ensuring that those who are born with a disability or who develop one early in life receive full state-funded care immediately; those who develop a disability later in life benefit from a cap on the overall costs that they face.

We also believe that our proposals support people with all types of care needs, 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 dementia, Parkinson’s disease and motor neurone disease – can face high lifetime care costs so, again, will benefit from the cap.

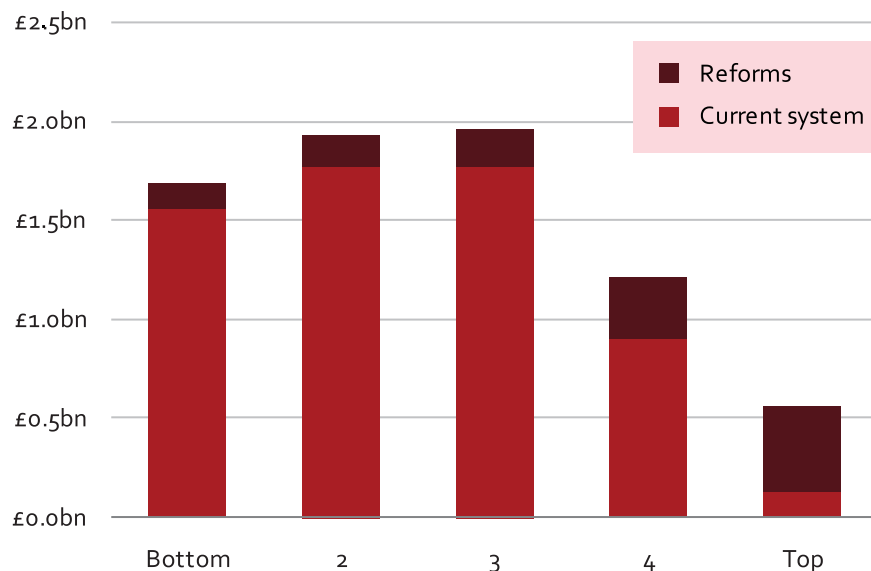
Impact on different income groups

Under our reforms, every income group is better off. As a proportion of income, the benefits of our proposals are distributed fairly evenly across different income groups.

In considering the distributional impact of our reforms, we also think it is very important that both the level of social care need and income are considered. For example, an analysis of the distributional effects of NHS spending would not just look at the impact of the NHS by income group,

but also how well resources were supporting people with high levels of health need. We think the same principles apply for social care. Figure 11 shows the net expenditure on older people, by income quintile, under the current system and under a reformed system incorporating our proposals.

Figure 11: Public expenditure in 2010/11 on older people's services by income quintile



Source: Commission analysis of ESHCRU/PSSRU microsimulation model results

Impact on specific groups

Gender

Because women are more likely to need care, and to be carers, we can expect that our proposals will have a particularly positive effect on them. Women have a higher risk of future care needs due to higher morbidity and longevity, and because they are less likely to receive care from their spouse when compared with men (because of age differences between spouses and life expectancy). The average expected future cost of care at age 65 is £25,000 for a man, compared with £44,000 for a woman.⁴¹ By limiting the overall costs of care over a lifetime, our proposals will therefore help women greatly. When designing any financial products to support people in meeting their personal contribution, the financial services industry will also need to consider how to take forward the new European Union directive requiring gender-neutral premiums for insurance products.

⁴¹ PSSRU modelling, 2011.

Ethnicity, religion or belief

People of different ethnic groups, religions or beliefs can have different outcomes under the current care and support system. For example, some people may face language or cultural barriers to accessing services, while other people may have special dietary requirements or needs to mark religious days in particular ways.

It may be that certain groups want to meet their care contribution in particular ways. Our proposals have been designed specifically to give people choice over how they meet their contribution. For example, some Muslims have specific requirements of 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 or direct payments under our model. This will mean people will continue to have choice and control over the way in which their care is delivered.

Sexual orientation

Gay, lesbian, bisexual and transgender groups will benefit from our reforms. We carried out deliberative research⁴² with these groups to better understand their views. This work, and that of previous consultations,⁴³ 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 that removes fear and uncertainty over future care and support.

42 Deliberative research was carried out for the Commission on Funding of Care and Support by TNS-BMRB. The full report has been published, alongside this report, on behalf of the Commission.

43 See the summary of the findings from the 'Big Care Debate', published in the White Paper *Building the National Care Service*, HM Government, 2010.

Potential further changes

Once the cap is in place, we think there are some other changes the Government may wish to consider to the means-tested system.

Consistent treatment of housing assets

At present, housing assets are treated differently across the social care means tests (domiciliary and residential) – the result is that different care settings are not on a level playing field. Individuals who may have a preference to receive care in their own homes have a financial incentive to do so; however, local authorities have an incentive to encourage movements into residential care to increase charge revenue. In the longer term, the Government may wish to rationalise these arrangements.

We know that making such a change would be difficult. Our public research reveals that using housing assets to pay for care is a very emotive issue. However, once a cap is in place, it may be easier for people to think about such a change. Our deliberative research indicates that people may be more willing to use some of their housing assets to pay for care if they know that will not have to spend the whole amount. To support changes of this kind a universal deferred payment scheme would need to be in place.

Introducing a taper into the means test

Once the cap is in place, we think the Government could also consider whether it wishes to introduce a taper into the means test to encourage people to save. For example, under the current system, those receiving home care see every extra pound above the minimum threshold (around £170 a week for older people) taken away in social care charges. Introducing a taper into the system would mean that people saw the benefits of having some savings. We think the taper could be set at 65% so it is in line with Universal Credit. This would mean that 65p for each pound of income above a minimum is chargeable income, rather than a pound in each pound, as is the case in the current system.

A consistent contribution to general living costs in residential and nursing care

We think that the Government should also consider whether those in receipt of NHS Continuing Healthcare should also make such a contribution towards their general living costs. In the future, it might seem unfair to those paying this contribution that someone in the same residential care home was not paying a similar contribution because they were funded via the NHS rather than through the social care system.

The cost of reform

Resources for social care

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 has meant many local authorities have had to prioritise services and spending. It would seem that these additional resources have not found their way to social care budgets in some areas. We believe it is important that further extra money identified for social care is spent on social care at the local level.

Looking forward the Government will need to devote greater resources to the adult social care system. In addition to funding for the new capped cost offer, there will also need to be additional public funding for the means-tested system.

Funding the current system

The current means-tested system is under extreme strain, and people are experiencing tightening eligibility and reduced care packages. The result of this is likely to be rising unmet need, poor outcomes and greater demands on the NHS. The Government will need to ensure that funding streams for local authorities are sustainable as change is implemented and beyond.

It is for the Government to take decisions on the level of funding of the means-tested system (the current system). We have made clear our view that the current system has been underfunded in the past. It has failed to keep pace with demographic change, not only with regard to services for older people but also those for people of working age. We believe that, over time, there have been more people not receiving all the care and support they need and that the demands being placed on carers have been increasing.

Cost of our proposed reforms

The three tables below show our central estimates of costs of our proposed reforms for England.

Figure 12: Summary costs (percentage of GDP)⁴⁴

	2010/11	2015/16	2020/21	2025/26
Current system				
Adult social care	1.16	1.19	1.28	1.39
DLA and AA	0.93	0.94	0.92	0.91
Additional costs of reform				
Costs of recommendations	0.14	0.16	0.19	0.22

Figure 13: Summary costs (£ billion), 2010/11 prices

	2010/11	2015/16	2020/21	2025/26
Current system				
Adult social care	14.5	16.0	19.0	22.8
DLA and AA	11.7	12.6	13.7	14.9
Additional costs of reform				
Costs of recommendations	1.7	2.2	2.8	3.6

Figure 14: Breakdown of costs of recommendations (£ billion), 2010/11 prices

	2010/11	2015/16	2020/21	2025/26
Care costs				
Capping costs at £35,000				
Older people	1.3	1.7	2.2	2.9
Younger adults	0.3	0.4	0.4	0.5
Raising upper threshold to £100,000 (after the cap is in place)				
Older people	0.1	0.1	0.1	0.1
Younger adults	–	–	–	–
Assessment and care management				
Older people	0.2	0.2	0.3	0.3
Younger adults*	0.0	0.0	0.0	0.0
Net social care	1.9	2.4	3.0	3.8
Benefits				
Older people	-0.2	-0.2	-0.2	-0.3
Younger adults	0.0	0.0	0.0	0.0
Net total	1.7	2.2	2.8	3.6

*Costs less than £0.05 billion

44 Costs are shown as a percentage of GDP for England. The percentages in this table differ from those produced by the Office for Budget Responsibility and quoted earlier. Our figures are based on the most recent information available.

Capped cost

We estimate that introducing a cap of £35,000, with a general living cost contribution of £10,000, would cost around £1.3 billion for older people in 2010/11. Introducing a cap along the lines we have proposed for working-age adults would cost up to £0.3bn in 2010/11, which is the cost of providing free care.

It will be up to the Government to consider how to balance setting the overall cap with the general living cost contribution. The table below illustrates the additional public expenditure required by level of cap and general living cost contribution.

Figure 15: Additional state expenditure on care for older people in 2010/11, by level of the cap and contribution to general living costs (£ billion)

		Cap level		
		£25,000	£35,000	£50,000
Living costs	£7,000	2.2	1.7	1.1
	£10,000	1.7	1.3	0.8

Sources: PSSRU microsimulation model, PSSRU aggregate models for younger adults and older people, UEA CARESIM, DWP expenditure tables, Commission analysis

There are also several reasons why the costs could be significantly lower than our estimates. For example, the cost of the cap for younger adults is likely to be lower than our estimate (which assumes free care) because many working-age adults with disabilities develop their disabilities in their fifties, by which time they might have accumulated significant assets and would be able to make a contribution to their care costs. Take-up of the capped offer could be lower than our estimate because higher wealth groups are less likely to take up any state support. Finally, we believe that there is likely to be a reduction in gaming the system, as the cap significantly reduces the incentive to dispose of or hide assets.

Changes to the means-tested system

Raising the threshold from £23,250 to £100,000 within the residential care means test is estimated to cost £0.1 billion more, once a cap is in place.

Other elements of reform

Other elements of our reforms will have some costs associated with them, and may result in some new burdens on local authorities. The cost of these other elements of our recommendations will depend on the way in which the Government decides to take them forward. However, we believe that many of these changes can be made at relatively low cost. For example, we believe that a universal deferred payments scheme could be cost neutral, if interest is charged by local authorities on the loan (although this may require an initial injection of cash); and an information and advice service can draw on many existing resources, such as the Money Advice Service and Directgov, and signpost people to other sources of external support such as Citizens Advice Bureaux.

We know that more people will need to be assessed. We estimate that our proposals will result in increased spending of around £0.2 billion on assessment and care management costs.

Moving towards a more objective, national framework for eligibility for care could involve spending more than in the current system. We think that setting a minimum national threshold at 'substantial' in the current system will have limited cost implications in itself, as this is around the level that most local authorities are currently starting to fund care. The cost of a more objective assessment process in the future would need to be modelled by the Government.

Paying for reform

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

- The Government may decide it wishes to raise additional revenue through general taxation. This is the way in which the current system is funded.
- It may choose to reprioritise existing expenditure, because it places greater value on this than other spending.
- 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 benefitting 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. If the Government decides to raise additional revenue, we believe it would be sensible to do so through an existing tax, rather than creating a new tax.

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

Chapter 7: Building the new system

Introducing the new funding system

Implementing with pace

Below we set out an ambitious timetable for implementation, which builds on the public commitment of the Government to move forward quickly with reform.

The Government has stated its wish to take forward reform of the care and support system's funding alongside reform of the social care statute and its own vision, in a White Paper this year. A social care bill will then follow.

We urge the Government to consider those elements of our reforms that can be taken forward immediately, in order to help alleviate the problems of the current system.

There are a number of different ways of introducing the capped cost scheme and it is for the Government to decide on the way 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 already been in residential care for two years⁴⁵ as well as all those born with a disability, or who have a care and support need and are under the age of 40 years of age. We understand that 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 – as such, consideration will need to be given as to how best this process can be managed.

⁴⁵ This represents around £35,000 of care costs.

A timetable for reform

Date	Activity
July 2011	Commission on Funding of Care and Support reports.
December 2011	<p>Government publishes White Paper bringing together our work, that of the Law Commission and the Government's vision for adult social care.</p> <p>Government to set up three working groups:</p> <ul style="list-style-type: none"> – one to develop a more objective, portable, national eligibility and assessment framework, and how this might align with disability benefits; – one to look at how to support the development of new financial products; and – one to design a new national and local framework for information and advice for those who need care and for carers.
2012	<p>Government introduces a bill on social care.</p> <p>Government sets out a firm timetable for the introduction of reforms – including the capped cost element and changes to the means-tested system.</p> <p>Government runs awareness campaign and starts to implement an improved information and advice service in collaboration with stakeholders.</p>
2013 onwards	Implementation of changes to the funding of adult social care.

A resilient system, for the long term

The care and support system is constantly evolving, responding to demographic, social, economic, legal, technological and political change. We want our proposed reforms to form the basis of a long-term, stable settlement.

To achieve this we know the system will need to be flexible over time. We are not suggesting that the overall shape of the settlement could change, because a large measure of certainty is necessary for encouraging people to plan and prepare, and for the development of financial products. However, we do want to ensure that there are

sufficient levers within the overall design so that the Government can respond to different political and fiscal pressures. These levers include the overall level of the cap, the setting of the eligibility threshold, and the operation of the means test (e.g. taper and tariff rates, and the income and asset thresholds).

In terms of the cap, we suggest that it is updated yearly on the same basis as the basic state pension. Furthermore, the Government may 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 retirement age, it might also ask the same body to review the level of the social care cap. Both of these measures would help build public confidence and reduce uncertainty. We think that this would not only help the financial services sector design and price products, but also help individuals and families in their financial planning.

Conclusions

Conclusions

Reform of the social care funding system is long overdue. We can wait no longer; the time for reform is now.

Our current funding system for adult social care is not working. It is widely perceived to be unfair, it is under-resourced, and many people are not receiving the care and support they need. In addition, it is difficult to understand and, even if people want to try and prepare for the future, there is little action they can take. The system is highly variable across the country, and services often do not work well together.

We urgently need a new settlement – one that takes away people’s fear and anxieties about the future, and helps them prepare for later life; one that better supports younger people with a care and support need to live active, independent lives; and one that recognises and encourages the valuable contribution made by carers.

We believe that our proposals are fairer than the current system. There is a clear, national offer, which should be backed up by better information and advice. The system facilitates choice and puts people in control. By focusing resources on those with the greatest need, while enhancing the well-being of everyone, it offers value for money. It is sustainable and resilient in the longer term. It is a better deal – one fit for today and for tomorrow.

Funding social care in the future is going to require more resources, both to address existing and future pressures and to implement the necessary reforms to improve the system. The extra resources will need to come from the state, from individuals and from carers, but we believe our proposals better balance the relationship between the three. By targeting public funding in the right place, we can assist individuals in making their financial contribution and support carers in their vital role.

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Commission on Funding of Care and Support *Fairer Care Funding: The Report of the Commission on Funding of Care and Support*

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406418a 1p 500 copies July 11 (Printflow)