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The Roadmap

England's choices for the care crisis

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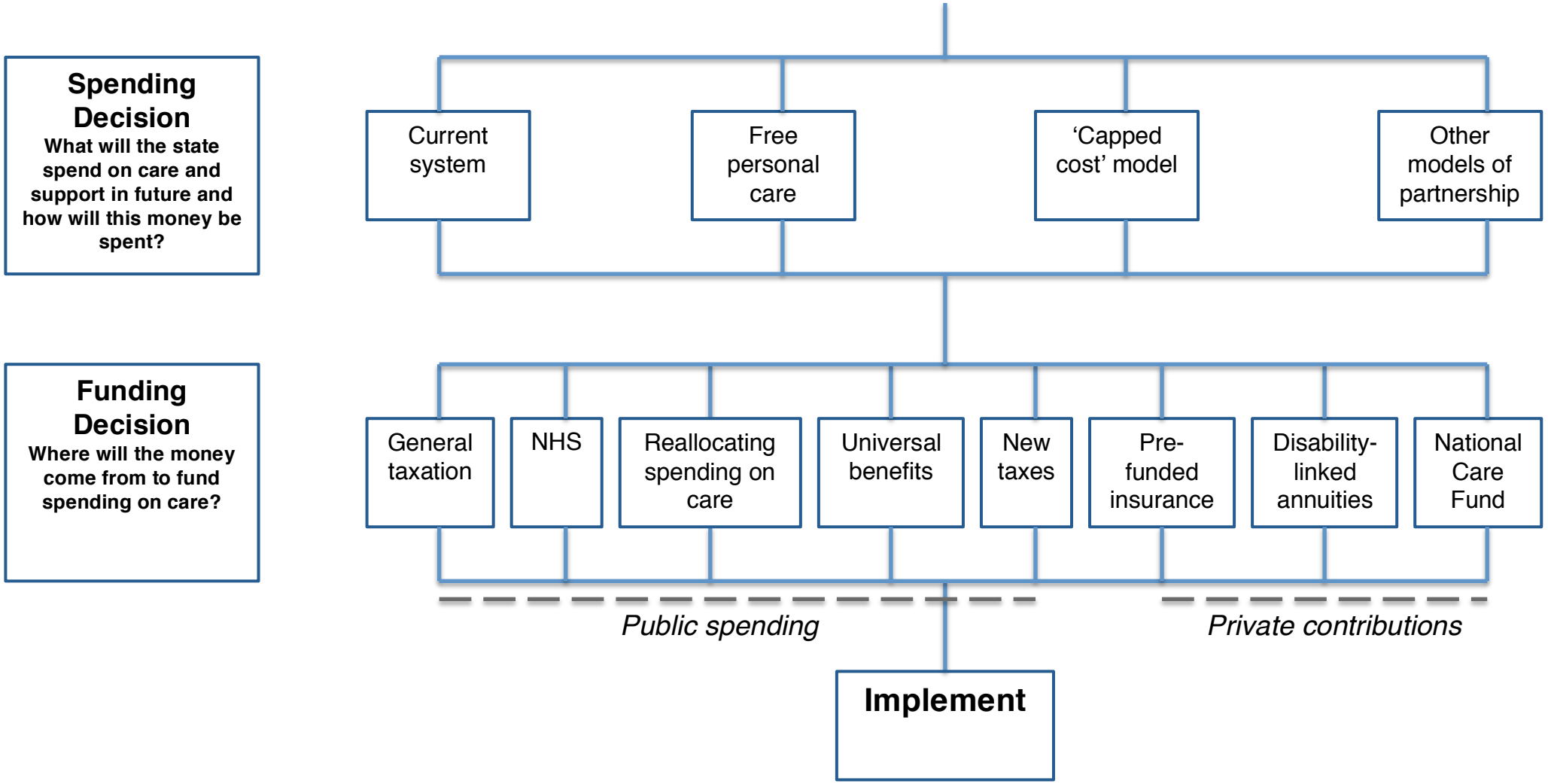
The Roadmap: England's choices for the care crisis



Executive Summary

This Roadmap describes the care crisis in England, and the options for the 'spending decision' and 'funding decision' the government must take.

England's care system is in crisis: unmet need; over-burdened family carers; catastrophic costs for those 'self-funding' care; a 'postcode lottery' in council support; and, care providers struggling to remain viable while providing quality services.

Demand for care is also rising in line with population ageing and increasing life expectancy among working-age adults with disabilities. Just to stand still, public spending on disability benefits and council support will have to increase in future. To address these problems, the government confronts two choices.

The first is the 'spending decision': what will the government spend on care and support in future and how will this money be spent? Will the current inadequate system be maintained, replaced with free personal care, or with a new 'partnership' between families and the state, such as the 'capped cost' model? Each option has different trade-offs, such as outcomes for users and costs to the state. Pressures on public spending are likely to preclude free personal care, so the government must decide on the best 'middle-way' partnership model between this and the current system.

The second choice is the 'funding decision': where will the money come from? Options include general taxation, as well as the NHS via direct budget transfers or 'spending better' through integrated health and care services. Existing public spending on care could be re-targeted away from wealthier households. Universal benefits, such as Winter Fuel Payments and free TV licenses could be reduced or means tested. New tax revenue could be raised from older workers or from the considerable housing wealth of the older cohort. The government could also seek to direct more private contributions from households into the care system via private insurance products or the creation of a *National Care Fund*.

Ultimately, multiple funding options are likely to have to be deployed, including a significant role for general taxation. Each option must be evaluated for feasibility, progressivity, outcomes for care users, and the volume of money each would direct into the system.

The government needs to have an honest conversation with the public about what sort of care system they want and how they want to pay for it. This means making the public aware of the core truths of the care funding challenge: we are all living longer, we are all going to need more care and support, and we are all going to have to pay for it.

Contents

1. The Roadmap: Introduction

England's care funding system is in crisis.

Care and support is what enables individuals with physical and cognitive impairments – many of them in old age - to maintain independence, control and quality of life.

Sometimes care is personal and intimate, such as help with using a toilet or getting out of bed. Sometimes it takes the form of services that everyone might use, such as a taxi or help around the home.

Family members are most often the ones to provide care and support, but many people also rely on support from paid care workers. People can receive care and support in their own home, but many of those with more substantial needs receive it in residential care facilities.

However, the way in which care and support in England is paid for is inconsistent, unfair and under-funded.

Problems with the current system will only increase over the next decade as the population ages and the need for care and support grows.

Reform of care funding in England is therefore both essential and inevitable.

To address this crisis, the government must make two decisions:

- **The 'spending decision'**: What will the state spend on care and support in future and how will this money be spent?
- **The 'funding decision'**: Where will the money come from to fund spending on care?

This Roadmap sets out the options for the government in making these decisions.

2. The Spending Decision

What will the state spend on care and support in future, and how will this money be spent?

Public spending on care and support in England takes two forms:

- Disability benefits are weekly cash-payments paid to individuals with defined levels of care needs regardless of their financial means. Recipients of 'Attendance Allowance' (over-65) and 'Disability Living Allowance' (under-65) can spend this money however they wish;
- Local authorities in England spend money on care and support for individuals because of a legal 'duty of care' toward their local population.

Local authorities apply a 'needs-assessment' to determine who they help and who they do not. If individuals are not having their care needs met by family members, the local authority will take responsibility and arrange support. Council help with care and support needs can take the form of direct provision of services, or cash payments to individuals to arrange their own support.

Local authority support for care in England is means tested. Individuals that fall below a threshold of income and wealth – the 'means test threshold' – will have support provided for free. But, if individuals are above this threshold of means, they will be charged for these services or may be turned away altogether.

Various proposals have been put forward for reconfiguring the Attendance Allowance system,[1] and reforms to Disability Living Allowance are currently ongoing.

However, it is the local authority care funding system that is universally regarded as requiring most urgent reform, and is the focus of this report.

The Spending Decision: What are the options?

This section of the Roadmap reviews the options for the Spending Decision confronting policymakers:

- The current system
- 'Free personal care'
- The 'capped cost' model
- Other 'partnership' models

This section concludes with observations on how government should go about making the 'spending decision'.

2.1 The Current System

How does public spending on care and support in England currently work and why does it need to change?

The local authority care funding system in England is built around assessments of need and assessments of means.

Multiple problems exist.

1) *Unmet need* - the amount of public money spent on care and support is inadequate, such that local authorities have to engage in excessive rationing and unmet need is pervasive. For example, Age UK

has used government data to calculate that spending on older people's care stagnated and then decreased between 2005-06 to 2011-12, despite the number of people aged over 85 actually increasing by 250,000 since 2004-05;[2]

2) *Quality* - in the context of under-funding, some organisations providing care struggle to remain viable, inevitably putting downward pressure on quality, and resulting in many care workers being poorly paid;
3) *Catastrophic costs* - individuals who do not qualify for local authority support can often find themselves compelled to spend many tens of thousands of pounds – 'catastrophic costs' – on care out of their own pocket. This can see individuals spending down much of the wealth they have taken a lifetime to accumulate, particularly when individuals have to 'self-fund' long periods in residential care by selling their home;
4) *Burden on family carers* - many family carers are left to provide intensive 'round the clock' care at great personal cost, preventing them from taking paid employment or having a reasonable quality of life. Isolation, stress and depression are commonplace;
5) *Postcode lottery* - local authority support for care varies among different councils, is unpredictable, and is often experienced as a 'postcode lottery'.

Is the current system sustainable?

In the background to existing problems with the current social care system, an important trend is unfolding: rising demand. Like many other countries, the population in England is ageing. In future, there will be more retirees as a proportion of the population than at present, and they will live for longer.

The result is that the need for care and support across the population in England is set to rise. As now, family members will meet most of this need for care. But the number of people who will seek support from local authorities will increase, as will the number entitled to disability benefits.

This trend has implications for public spending. As demand for care and support in England grows, future governments will have to spend more on disability benefits and the local authority care system just to maintain support at equivalent levels to today.

This 'funding gap' will grow significantly over the next two decades.

What will be the cost of maintaining the current system?

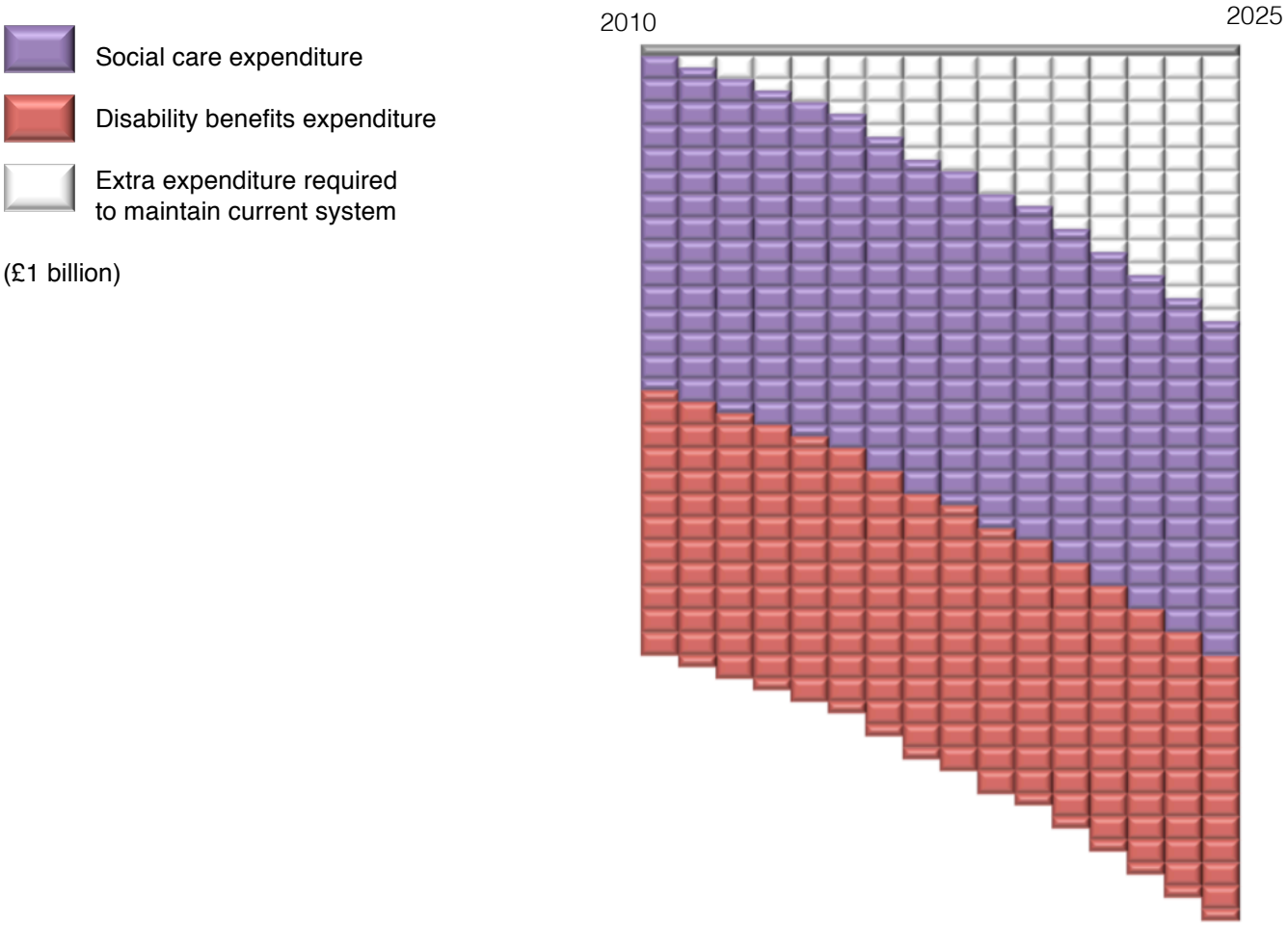
Given rising demand, public spending on care and support for adults England must grow over the next 15 years, if levels of spending 'per person' are to remain at the same level as today.

In short, just to 'stand still' public spending on care and support will have to increase.

The graph below shows the amount of money – in 2010 prices - that will have to be found in order to maintain the current system, including the cost of disability benefits (the 'care component' of Disability Living Allowance for older people and working age adults, as well as Attendance Allowance for older people).

The graph below shows what happens by holding constant expenditure on social care and disability benefits. The white blocks – each representing £1 billion – show the extra amount that must be found.

Current and Future Public Expenditure on Adult Care and Support in England, 2010-2025 (2010 prices)



By 2025, an extra £11.5 billion of public spending will have to be directed to care and support, in 2010 prices, just to maintain the current system.

However, over this period, gross domestic period (GDP) will also grow, so it is important to also present these figures in terms of GDP. These projections, drawing on the work of the Commission on Funding of Care and Support, assume that care costs rise in line with GDP growth over the entire period.

	2010/11	**2015/16**	**2020/21**	**2025/26**
Net social care	14.5	16.0	19.0	22.8
Disability benefits	11.7	12.6	13.7	14.9
Total	**26.2**	**28.6**	**32.7**	**37.7**
£ billion extra	-	+2.4	+6.5	+11.5
GDP				
Adult Social Care %GDP	*1.16%*	*1.19%*	*1.28%*	*1.39%*
Disability benefits	*0.93%*	*0.94%*	*0.92%*	*0.91%*
Total GDP	***2.09%***	***2.13%***	***2.2%***	***2.3%***
Total %change in proportion of GDP	***-***	***2%***	***5%***	***10%***

Just to 'stand still', the proportion of GDP spent on care and support by 2025 will have to increase by 10%. This is the cost of maintaining a system that many people already believe to be broken and inadequate, and which results in unmet need.

More detail on the cost of maintaining the current system is contained in Appendix 2.

Conclusion

There is universal recognition that the long-term care funding system in England requires reform. Today's broken system will only become more expensive in future. Difficult decisions on how to pay for it are therefore inevitable.

For government, the choice is therefore whether to let the current system stumble on, or take a positive decision to create a better, fairer, system.

The next sections review the options for doing this.

2.2 Free Personal Care

Some stakeholders have consistently called for the introduction of free personal care in England.

Under this model, all public spending on care and support – and not just disability benefits – would be 'free', and allocated regardless of a person's income or wealth.

It is argued that local authorities should cease means testing individuals and should instead allocate funding for care regardless of someone's ability to pay. This would make the local authority social care system much more like the National Health Services (NHS) in England, which is free at the point of use.

Such a reform to public spending on care in England represents the most generous possible reform option.

Would 'free personal care' mean that no one would ever have to spend anything on their care again?

No. Free personal care does not mean that all care is free to everyone all of the time. In particular, it does not mean that individuals would be able to spend what they wished on care, and then have their costs reimbursed by their council.

Instead, 'free personal care' simply means that councils would no longer use means tests to determine who receives support.

However, local authorities would still use needs-assessments to allocate support, and they would continue to adjust levels of support provided for someone in their own home according to how much informal care is available, i.e. 'free personal care' would be 'carer-sighted', not 'carer-blind'. As such, if a person was able to wholly rely on a family member for care, they would – as now – not be entitled to council funding for care.

It is also important to note that even if they no longer charge for services or undertake means tests, councils would still be able to ration support by changing their 'eligibility criteria', i.e. the threshold of care needs individuals must have in order to receive support. For this reason, if the introduction of 'free personal care' was not matched with greater resources from central government, many councils would likely respond by raising eligibility thresholds.

What would individuals have to pay under 'free personal care'?

Under a system of 'free personal care', individuals would still have to pay for various types of expenditure out of their own pocket:

- *Accommodation costs* – even under 'free personal care', individuals in residential care would still be charged for different types of 'accommodation costs', i.e. the costs of rent, food, electricity, etc.
- *'Top-up' fees* - individuals in residential care who opted for care homes that charged more in weekly fees than what their council would pay for would have to pay 'top-ups' from their own resources, which may amount to several hundred pounds per week. In some circumstances, these top-ups would continue to result in accumulated bills of many tens of thousands of pounds. Around 40% of older people in residential care are 'self-funders', and the vast majority pay more than the average amount paid by their council for places in residential care.

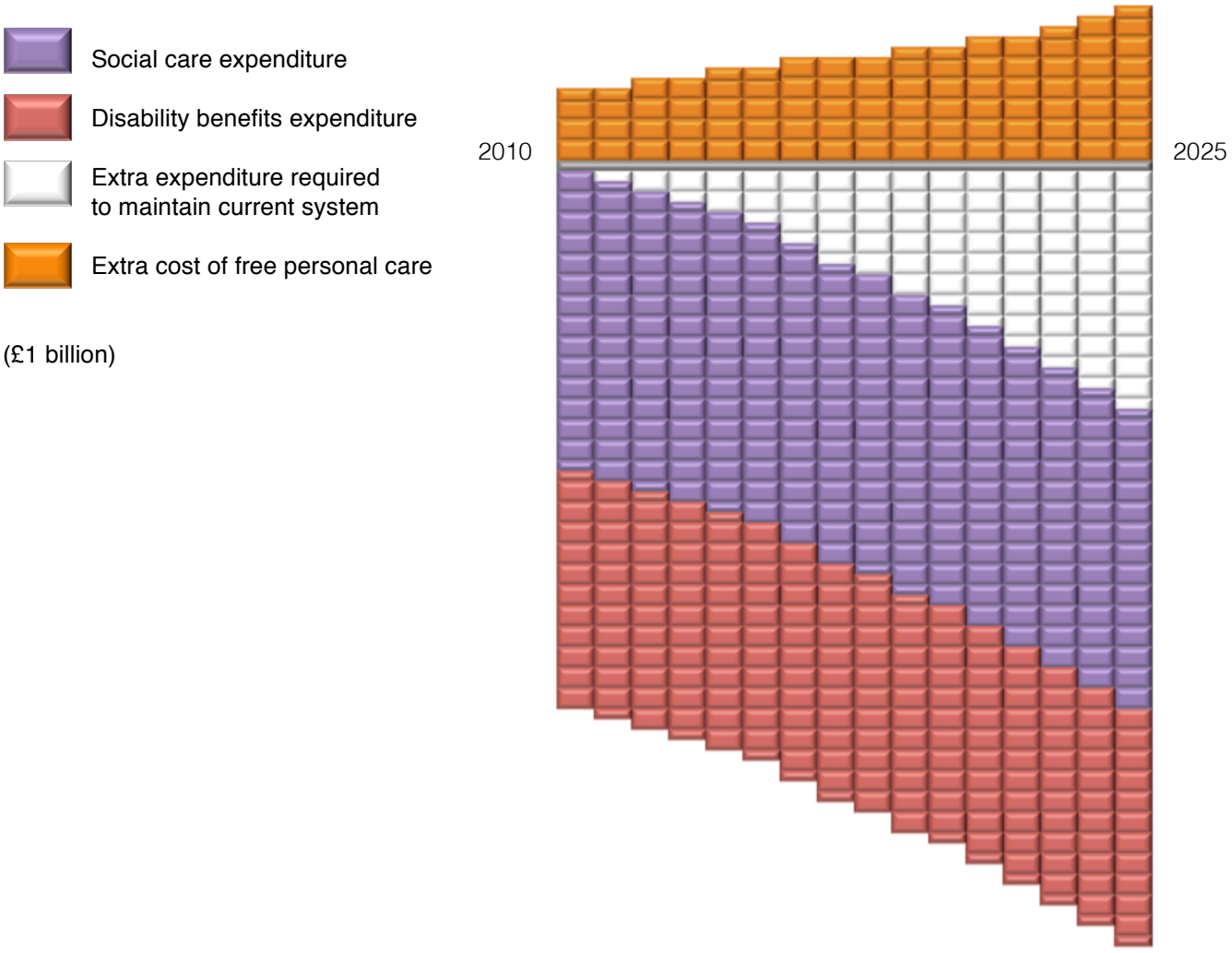
For these reasons, even under 'free personal care', some individuals would be likely to experience 'catastrophic costs', and spend down many tens of thousands of pounds on their care. The difference in residential care fees between what self-funders and councils pay is significant for all possible reforms, including those examined in later sections, and has been explored in academic research.[3]

Nevertheless, it is worthwhile noting that given 'self-funders' in residential care would only have to pay 'top-ups' under free personal care, most self-funders would then be able to use insurance – specifically 'immediate needs annuities' - to protect themselves from 'catastrophic costs' when going into residential care.

What would be the cost of free personal care in England, given today's eligibility thresholds?

If levels of support were to remain broadly equivalent to today's levels, estimates of the costs of introducing free personal care *for older people only* (in 2010 prices) are as follows:

Free Personal Care for Older People: Public expenditure up to 2025, (2010 prices)



Free Personal Care: Public expenditure up to 2025
(2010/11 prices)

	2010/11	2015/16	2020/21	2025/26
Current system				
Older people care	6.6	7.4	8.8	10.8
Younger adults	5.9	6.3	7.4	8.6
Total assessment and care management	2.0	2.3	2.8	3.4
Total social care costs	**14.5**	**16.0**	**19.0**	**22.8**
Extra costs of free personal care for older people				
Free adult personal care	3.8	-	-	7.7
Total	**18.3**	**-**	**-**	**30.5**

Source: Commission on Funding of Care and Support (2011) *Fairer Care Funding Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support*

If 'free personal care' for older people were implemented with today's typical eligibility-thresholds applied, this would cost an extra £3.8 billion rising to an extra £7.7 billion in 2025. If free personal care were introduced for all adults, a reasonable rough estimate of the extra cost on top of this would be £1 billion per year.

Importantly, these estimates exclude any potential demand effects, i.e. more individuals coming forward for support from their local authority because they will not be means tested. These figures also refer to additional care costs only, and do not include general living costs in residential care, nor the extra costs of assessments.

Comment

Many stakeholders continue to believe that free personal care is the best, fairest option for reforming funding of care and support in England. However, as this brief review has identified, free personal care would not mean that individuals would no longer have to pay toward their care costs, and would no longer experience catastrophic costs.

It is also important to highlight the significant extra cost of free personal care to the Exchequer. As many commentators have also pointed out, if the cost of free personal care – which would particularly benefit older households with property wealth – was funded through a higher tax burden on younger cohorts, this would raise serious questions around 'intergenerational fairness'.

2.3 The 'Capped Cost' Model

The previous sections have looked at the least generous and most generous options for reforming the local authority care funding system.

However, between the extremes of the current system and 'free personal care', multiple reforms are possible, representing an improved 'partnership' between individuals and the state. One option is the 'capped cost' model put forward by the Dilnot Commission on Funding of Care and Support.[4]

The 'capped cost' model would see the financial value of local authority support that individuals are excluded from owing to their wealth capped at £35,000. In addition, the local authority means test threshold for residential care – the Upper Capital Limit – would be increased to £100,000.

How would the 'capped cost' model work?

The 'capped cost' model has two core components.

'Cap' on costs

The first component is a 'cap' on costs, which the Commission recommended should be set between £25,000 and £50,000, with £35,000 the preferred level.

Individuals would, as now, have their care needs and means assessed by local authorities who would continue to determine the financial value of support they give to individuals with particular levels of need.

Individuals whose wealth put them *above* the means test threshold would, as now, not receive support. But, when the *accumulated financial value* of support that individuals have missed out on owing to their wealth reached £35,000 – recorded by councils using periodic needs-assessments - individuals would then begin receiving support just as if they were below the means test threshold.

The 'capped cost' model therefore caps the amount of means tested local authority support that individuals are excluded from owing to their wealth.

For 'self-funders' in residential care who do not qualify for local authority support, their council would allocate 'notional amounts' based on how much that council spends on care home fees in their area. The current average gross weekly expenditure by councils in England per older person in residential care is estimated at £461 per week.[5] When these notional amounts reached £35,000, individuals would be entitled to the amount that their council pays toward places in residential care.

Means Test Change: Increase to the Upper Capital Limit

The second component of the 'capped cost' model is an increase in the Upper Capital Limit means test threshold for residential care from £23,250 to £100,000.

This would see individuals in residential care with wealth between £14,250 and £100,000 expected to make a contribution out of their assets, calculated by assuming that they can afford an extra £1 per week for every £250 of assets they have above the £14,250 threshold (i.e. 'tariff income').

In effect, individuals in residential care with 'assessable wealth' between £14,250 and £100,00 would cease to pay their residential care fees out-of-pocket – apart from any 'top-up fees' - and would instead pay subsidised charges to their council.

For poorer individuals, for example, with a £60,000 home, the increase in the Upper Capital Limit is arguably more important than the 'cap'. This is because instead of – as now – being forced to pay for their residential care fees on their own, such individuals would find themselves below the means test threshold and entitled to subsidised charges before they had reached the 'cap'.

What would the 'capped cost' model mean for individuals?

The 'capped cost' model would significantly reduce the number of individuals with high levels of need being compelled to spend very large proportions of their wealth on their care: so called 'catastrophic costs'.

However, in addition to the cost of any care that they purchase before they reached their council's 'cap', under the 'capped cost' model, individuals would still be liable for:

- *Accommodation costs* – as now, contributions toward various costs in residential care, such as rent, food, electricity, etc. would be expected of individuals, even after they had reached the 'cap'. The Dilnot Commission recommended that, for older people, the government set a contribution towards general living costs of between £7,000 and £10,000.
- *'Top-up' fees* – 'self-funders' in residential care who opted for care homes that charged more in weekly fees than what their council would pay for would have to pay 'top-ups' from their own resources. These may amount to several hundred pounds per week.

As with 'free personal care', under the 'capped cost' model, some individuals would continue experiencing catastrophic costs. This is because most self-funders in residential care pay *more* in weekly fees than the average amount paid by their local authority.

This means that most self-funders in residential care would have spent more than £35,000 by the time that the 'meter' of council support that they had been excluded from reached £35,000. And, beyond this point, most self-funders would continue to pay 'top-up' fees, which could amount to several hundred pounds per week, because their council would only contribute the amount it pays for residential care placements, which is almost always significantly lower than the fees that self-funders pay.

Will the 'capped cost' model encourage individuals to buy pre-funded insurance?

No. The Dilnot Commission was extremely clear that it did not think it likely that there would be "significant growth in specific, pre-funded long-term care insurance products", in response to the introduction of the 'capped cost' model.[6] This view has been confirmed by independent analysis from the Strategic Society Centre[7] and by the Association of British Insurers.[8]

Is the 'capped cost' model fixed in stone?

No. As the Dilnot Commission noted, the 'cap' can be set at different levels, although a threshold between £25,000 and £50,000 was recommended. In addition, there is no reason that the Upper Capital Limit means test threshold for residential care might not also be set at different levels. Different aspects of the 'capped cost' model could be introduced at different times dependent, for example, on the state of public spending.

It is also worth noting that the 'capped cost' model itself could be seen not as an 'end-point', but as a 'stepping-stone' to a more generous system in the future.

Are there other issues to consider?

In implementing the 'capped cost' model, policymakers would need to consider various issues, in addition to the thresholds of the 'cap' and the Upper Capital Limit.

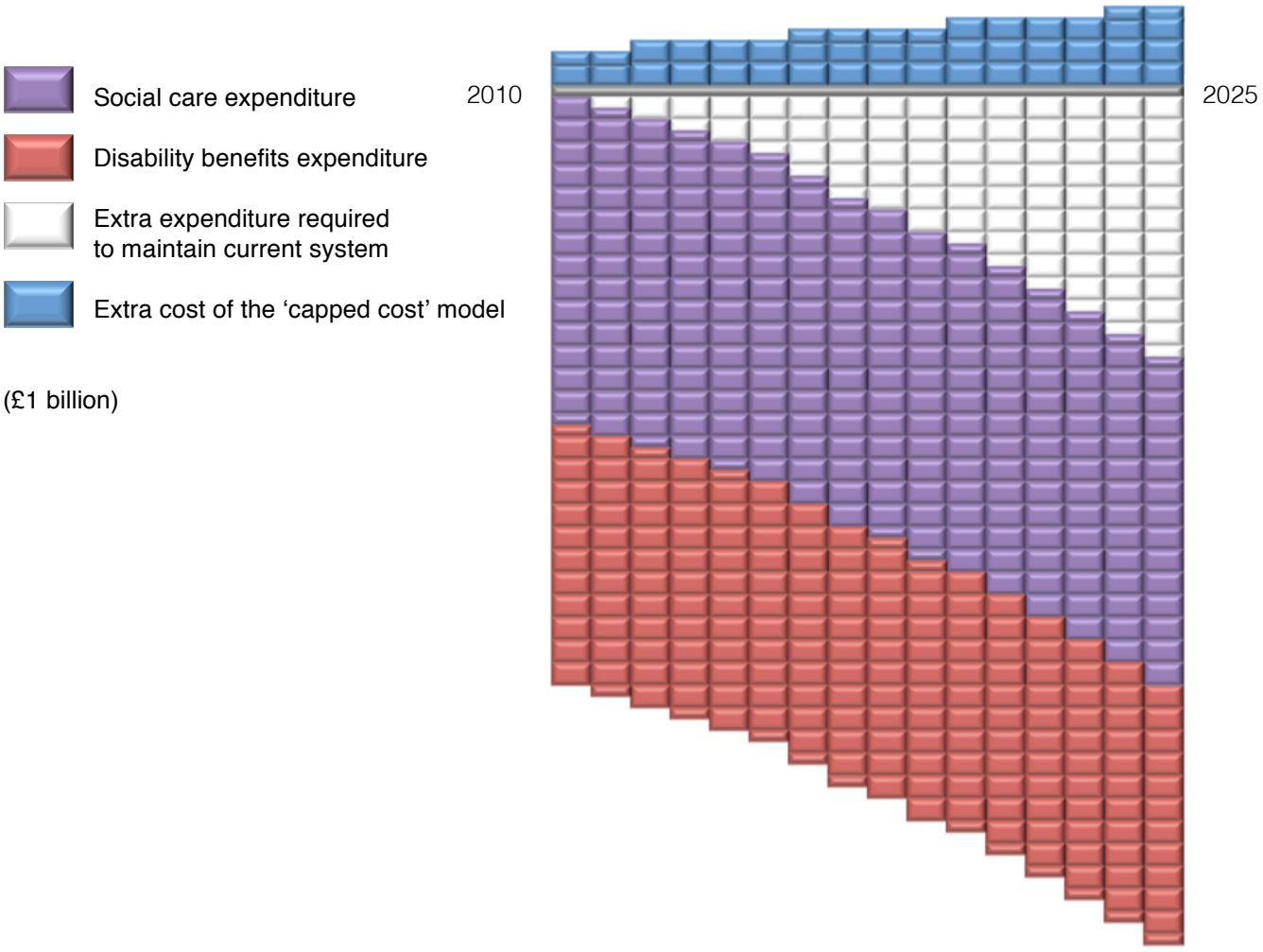
These would include: the administrative feasibility of 'metering' individuals by councils; the effect on incentives for gaming the system resulting from the cap; and most importantly, how the model would be paid for given that – like free personal care – it involves more public spending allocated to higher income individuals above the current 'safety-net'.

In the absence of any evidence from other countries regarding how a 'capped cost' scheme would work in practice, policymakers would need to be careful to identify unforeseen outcomes.

What would be the cost of the 'capped cost' model over the next 15 years, given current eligibility thresholds and a 'cap' of £35,000?

According to projections from the Commission on Funding of Care and Support, assuming that the 'capped cost' model was operating by 2015 with a £35,000 'cap', the extra cost to the public purse would be £2.2 billion that year, rising to £3.6 billion extra by 2025.

Cost of the 'capped cost' model with £35,000 cap up to 2025 (2010 prices)



To implement a 'cap' of £35,000 on top of maintaining the current system, the government would have to find an extra £15 billion per year by 2025, compared to 2010. Put another way, to implement the 'capped cost' model would require the proportion of GDP spent on care and support by the state to increase by 20% by 2025:

	2010/11	**2015/16**	**2020/21**	**2025/26**
Current system				
Older people care	6.6	7.4	8.8	10.8
Young adults	5.9	6.3	7.4	8.6
Total assessment and care management	2.0	2.3	2.8	3.4
Total care costs	**14.5**	**16.0**	**19.0**	**22.8**
Extra costs of 'capped cost' model				
'Capped cost' model	1.7	2.2	2.8	3.6
Total	**16.2**	**18.2**	**21.8**	**26.4**
GDP				
Total % of GDP for current system	*2.09%*	*2.13%*	*2.2%*	*2.3%*
Extra cost of 'capped cost' model as % of GDP	*0.14%*	*0.16%*	*0.19%*	*0.22%*
Total % GDP for 'capped cost' model	*2.23%*	*2.29%*	*2.39%*	*2.52%*
Total %change in proportion of GDP from current system in 2010	*6%*	*10%*	*14%*	*20%*

Source: Commission on Funding of Care and Support (2011) *Fairer Care Funding Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support*

2.4 Other Models of 'Partnership'

Other 'partnership' reforms are possible that could be implemented alongside the 'capped cost' model.

Like the 'capped cost' model, these options represent different settings of the 'control dials' that determine the shape of how local authorities spend money on care and support in England:

- Needs threshold for eligibility for council support;
- What constitutes 'assessable wealth' in council means tests;
- Upper Capital Limit;
- Lower Capital Limit;
- Percentage of assessed 'care costs' funded by councils.

This section reviews what would happen if two of these control dials were changed:

- Introduction of a percentage 'co-payment' toward assessed care costs for all individuals regardless of wealth ('King's Fund Partnership Model')
- Raising the Lower Capital Limit for residential care ('Means test Plus')

These options are not mutually exclusive from each other or indeed other models of 'partnership' such as the 'capped cost' model. All could be implemented separately or together.

1) Co-payments: 'King's Fund Partnership model'

The 'King's Fund Partnership' model was first put forward by Derek Wanless in 2006,[9] and was subsequently updated in 2010.[10]

The underlying principle of the model is 'progressive universalism': everyone in the local authority social care system should receive something, but proportional to means.

In the 'King's Fund Partnership model', local authorities undertake needs-assessments, and then fund at least one-third of the assessed care costs of everyone with qualifying levels of need. Those who are above the council means test threshold would have to fund their remaining costs themselves. The poorest individuals – those below the means test threshold – would, as now, continue having all of their care costs paid for by the council. In this way, the 'King's Funding Partnership Model' ensures 'something for everyone', as well as providing greater financial support and asset protection for individuals who would currently be above the means test threshold of council support.

What would the 'King's Fund Partnership Model' mean for individuals?

The key attribute of the 'King's Fund Partnership model' is to ensure that all individuals with qualifying needs receive at least something from their council, regardless of wealth.

Under the basic version of the 'King's Fund's Partnership model', the poorest individuals would have all of their social care costs funded by local authorities, and everyone else would have 33% of their costs funded.

For care in the home, 33% of the cost of assessed needs by local authorities might amount to modest amounts of money.

For residential care, 33% of the average amount that local authorities fund would represent significantly more in cash terms. However, as with the 'capped cost' model described above, those self-funders (the vast majority) who spend more on weekly residential care fees than their council would have to pay 'top-ups'. As a result, the

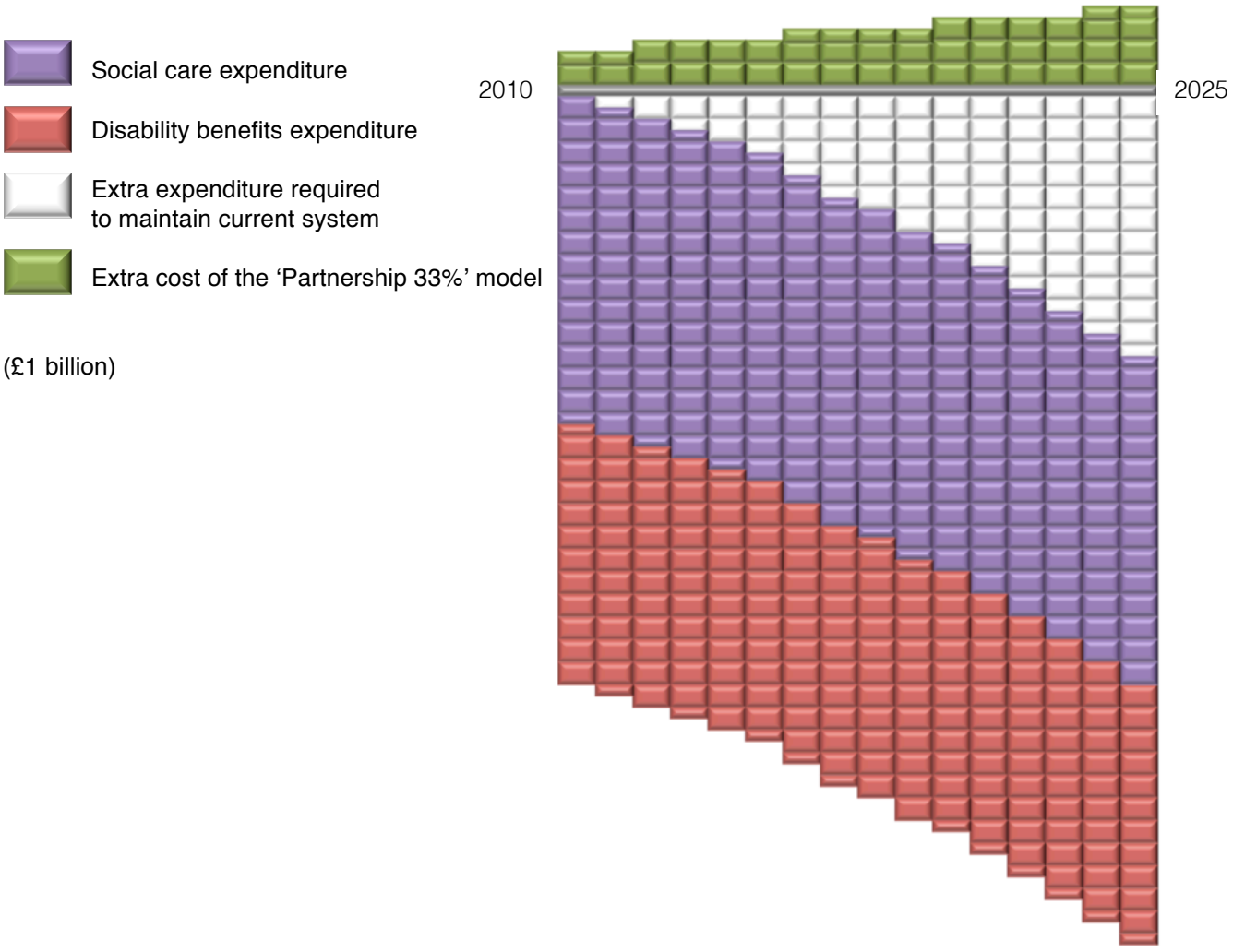
amount received would likely be less than 33% of the costs that they actually pay, and some individuals would continue to experience 'catastrophic costs'.

What would be the cost of the 'Partnership model' over the next 15 years, given current eligibility thresholds?

The 'Partnership model' can be made more or less expensive and generous, depending on the proportion of care costs funded by the council. Projections by the Commission on Funding of Care and Support suggest the extra cost to the Exchequer of funding at least 33% of everyone's assessed care costs would cost the same as the 'capped cost' model described in the previous section, with a cap of £35,000.

This 'Partnership 33%' model would therefore cost an extra £2.2 billion in 2015, rising to £3.6 billion in 2025.

The Costs of the 'Partnership 33%' model, up 2025 (2011 prices)



2) Raising the Lower Capital Limit for Residential Care ('Means test Plus')

The 'Means test Plus' model is built around a simple idea: raise the means test thresholds of the current system in order to increase the asset protection it provides to individuals. A paper published by the Personal Social Services Research Unit (PSSRU) explored what this model would mean for public expenditure, asset protection and outcomes.[11]

At present, councils effectively charge individuals for subsidised services between a Lower Capital Limit (£14,250) and an Upper Capital Limit (£23,250). It is the Lower Capital Limit that provides most asset protection: individuals with assessed wealth below this level receive the full value of their assessed personal care costs.

Under the 'Means test Plus' model, the Upper and Lower Capital limits for residential care would be merged at a new, higher threshold, for example, £150,000. Individuals with wealth below this threshold would be entitled to the full amount that their council pays for places in residential care.

A key feature of such a model is its simplicity: it only involves 'pulling a single lever' of the current system in order to achieve a specific outcome - a more generous 'floor' of asset protection for individuals in residential care.

What would Means Test Plus mean for individuals?

Individuals in residential care spending down their wealth to the new threshold of £150,000 would then be entitled to the full amount that their local council pays toward residential care fees.

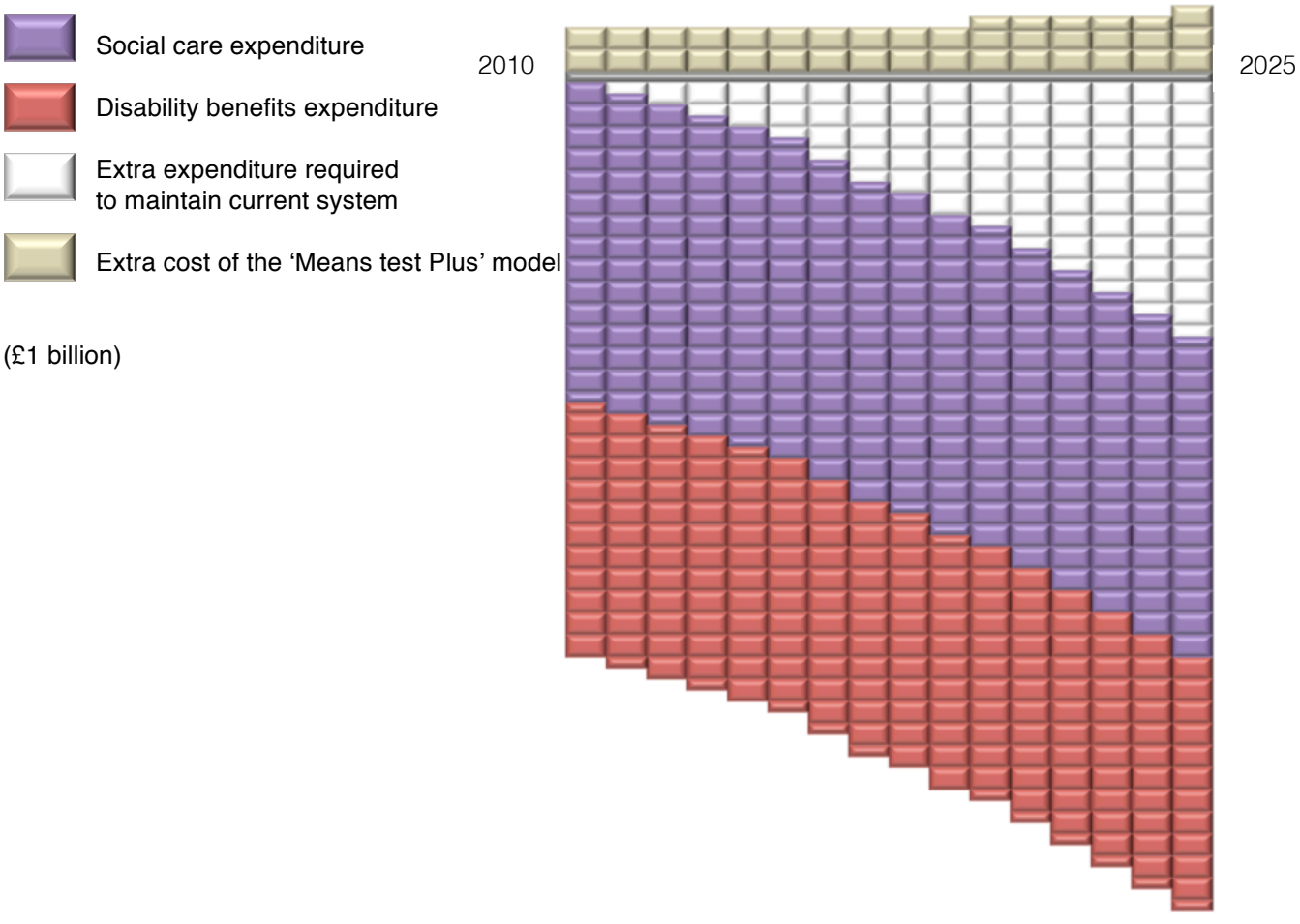
However, as now, many would still contribute toward their 'accommodation costs' (food, heating, etc.) from any pension and benefits income.

In addition, as with the 'free personal care' and 'capped cost' models, self-funders in residential care whose weekly fees cost more than the maximum amount their local authority would contribute would have to carry on paying 'top-up' fees even after they had reached the £150,000 means test threshold.

What would be the cost of Means Test Plus over the next 15 years given current eligibility thresholds?

If the new single (Lower) Capital Limit under Means Test Plus were set at £150,000, the following costs have been estimated:

The Costs of 'Means Test Plus' up to 2025, £150,000 capital threshold (2010 prices)



The Costs of the 'Means test Plus' Model: £150,000 threshold

	2010/11	2015/16	2020/21	2025/26
Current system				
Older people care	6.6	7.4	8.8	10.8
Young adults	5.9	6.3	7.4	8.6
Total assessment and care management	2.0	2.3	2.8	3.4
Total social care	**14.5**	**16.0**	**19.0**	**22.8**
Extra costs of MTP model				
MTP model	1.8	2	2.4	2.8
Total	**16.3**	**18**	**21.4**	**25.6**

Source: Forder J and Fernandez J-L (2011) *Funding social care for older people: The implications of extending the current means test*, Report commissioned by Bupa Care Services, PSSRU Discussion Paper 2821, Canterbury: PSSRU

2.5 How to Make the Spending Decision

What are the key factors that should guide how policymakers make the 'spending decision'?

The current system cannot continue

The arguments for reforming how public money is spent in the social care system are universally acknowledged. Reform is essential and inevitable.

Whatever happens, public spending on care and support will have to increase

The question of how much to spend on social care cannot be ignored. Public spending will have to go up, even just to maintain the current system. The choice is therefore between facing up to difficult choices to maintain the current system, or difficult choices to implement a new, better, fairer system.

No perfect model exists, and each embodies trade-offs

The options for redesigning government spending in the care and support system can be evaluated in different ways:

- Outcomes – what outcomes will result for care users and their families?
- Asset protection – what will be done to protect the wealth of those experiencing the highest costs?
- Cost – what will be the costs of a new system for the state and for families?
- Incentives – what incentives will result for families and carers?
- Prevention – is prevention of care-related need and costs facilitated and incentivised?
- Integration – is the integration of health and care services helped or hindered?
- Transition costs – what will be the costs of switching from one system to another?
- Administrative costs – what administrative costs would result from a new system?

Ultimately, the priorities of politicians will reflect how these are assessed and no 'perfect' model exists.

The best 'middle-way' partnership option must be found

Although many stakeholders remain attracted to the model of free personal care - and there is no reason to rule it out in the long-term - given the pressures it would impose on public spending in the short to medium-term, it is unlikely to be realised in the near future.

As such, the challenge for policymakers is to settle on the best 'middle-way' option between free personal care and the current system, which represents an improved partnership between individuals and the state in paying for care.

It is up to politicians to decide which configuration of the 'control dials' best reflects their priorities and those of care users.

There is scope to pilot different options

Good policymaking relies on the piloting of significant policy reforms in order to identify problems and test whether expected benefits are secured in practice.

The local authority social care system in England, which effectively comprises 152 separate social care systems, is ideally suited to piloting new schemes in a handful of areas before implementation at a national level. Indeed, such an approach has been observable across much of social care policy over the last decade.

There is a significant lack of evidence for policymakers to draw upon regarding how proposals – including those described above – for reform of the local authority social care system in England would work in practice.

For example, no council has experience of offering co-payments to all individuals with qualifying needs, nor of operating a 'metering system' required by the 'capped cost' model.

As such, one option for policymakers in the short-term is to pilot different options before making a final decision.

Ultimately, it is the 'funding decision' that is most important

Although the public should have clarity regarding the shape of public support for care costs, the precise shape of state support can be tweaked and refined on an ongoing basis, by different governments and at different times, reflecting different fiscal conditions, political priorities and – most importantly – evolutions in how care and support is provided alongside health and housing services.

But however politicians decide to implement a new partnership between individuals and the state for paying for the costs of care and support, it is ultimately the question of where the money required comes from – the 'funding decision' – that is more important.

3. The Funding Decision

Where will the money come from to fund spending on care?

Simply maintaining the current care and support system in England will require an extra £11.5 billion per year by 2025, compared to 2010, to be found for entitlements to disability benefits and local authority support to remain at equivalent levels as today. Put another way, by 2025, just to 'stand still', the proportion of GDP spent on care and support will have to increase by 10%. The principal cause of this change is population ageing.

As such, it is inevitable that policymakers will have to find more money just to address the growing 'funding gap' in the English social care system. If a new, more generous system is implemented – as widely demanded by stakeholders – even more money will have to be found.

This section of the Roadmap explores where the money will come from to fund public spending on care and support, such as the NHS, changes to universal benefits and new taxation.

This section also explores the options for bringing more money into the social care system via new private contributions from households in a way that may reduce pressure on public spending, such as pre-funded insurance or the creation of a *National Care Fund*.

What is not examined here?

This section excludes mechanisms for individuals to pay for their care that do not involve risk-pooling, for example, public ('deferred payment schemes') and private ('equity release') sector mechanisms for individuals to effectively borrow against the value of their home to fund care out-of-pocket.

Also excluded are immediate needs annuities (INAs). These are an insurance product purchased for a lump-sum payment when individuals move into residential care, and which pay a regular income to cover residential care fees until a person dies, whether after 1 year or 10 years, thereby protecting individuals from 'longevity risk'. Although the use of INAs may reduce the number of individuals spending down their wealth and falling back on council support – and projections show this could save as much as £150 million across England in some scenarios[12] - INAs do not bring new money into the care and support system: they help individuals use the money that they would have spent in a more optimal way.

What effect might trends in GDP have on the 'funding decision'?

The size of the care funding challenge confronting policymakers over the next decade will be determined by trends in both Gross Domestic Product (GDP) and inflation in the unit costs of care.

The real burden posed by maintaining the current spending in future years will depend on the interaction of Gross Domestic Product (GDP), inflation and unit costs of care. Two scenarios can be conceived:

- If average unit costs of care rise faster than GDP, this will see the real cost of the current social care system increase, on top of the effect of rising demand;
- If the average unit cost of care increases more slowly than GDP, the cost of the care funding system will become proportionately more affordable.

In its projections, the recent Commission on Funding of Care and Support assumed that unit care costs will rise in line with expected GDP growth of around 2%, i.e. broadly in line with earnings.[13]

However, the Commission also set out the effect of alternative assumptions on the modelling, as a percentage change on the 2010 base case, in 2025:

- If the unit cost of care grew 1 percentage point faster than the base care (3%) per year, costs in 2025 would be 17% higher.
- If growth in the unit cost of care grew 1 percentage point slower than the base case, costs in 2025 would be 15% lower.

Is it right to assume that unit care costs rise in line with expected GDP growth? Although this has been the case in the past, the Commission provides a useful summary of the reasons to think this may or may not be the case:

- "Unit costs of care could exceed the growth rate of the economy. This could occur if growth in wage rates in the care sector exceeded that on average across the economy, for example due to a lack of supply of labour in the sector, or if the reforms stimulated demand for formal care services faster than supply could respond, such that providers could increase real prices without losing custom.
- Unit costs of care could change as a result of changes in people's expectations (for example about quality of care), government policies or regulatory changes.
- Unit costs of care could fall short of the growth rate of the economy. This could occur if, for example, wages of care staff rose more slowly than average earnings or technological advances meant that people's ability to remain independent was enhanced with lower cost interventions. Examples of this are already in evidence, such as telecare, the unit cost of which may be lower than having a formal carer regularly visit a person's home."

  Source: Commission on Funding of Care and Support (2011) *Fairer Care Funding: Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support*

What does this mean for the future funding of care and support?

The key point is that if GDP grows faster than inflation in average unit care costs, then some of the 'funding gap' by 2025, would effectively be met through increased affordability. However, there is also a downside risk, and weak GDP growth may proportionately enlarge the care funding challenge that confronts policymakers.

3.1 General Taxation

Could the care funding challenge be met entirely out of general taxation?

Although the government could simply decide to fund the current system in future – or even 'free personal care' - entirely out of general taxation, there are two arguments against doing this.

The first issue is affordability. Multiple different areas of public spending make claims on general taxation, such as education, the NHS and the State Pension. In addition, the global financial crisis that began in 2007 has seen the UK economy contract, and left the UK Exchequer confronting an unprecedentedly large structural deficit in public spending that will require the size of state spending to shrink, not grow. This pressure on public spending is exacerbated by population ageing and the declining 'elderly support ratio'. The result is that the affordability of funding the care system out of general taxation is a key concern for policymakers.

However, more recently, policy analysts have highlighted issues around the intergenerational fairness of simply using general taxation to fund an improved care funding system in England. This is because the bulk of general taxation is derived from various taxes on the working-age population, such as income tax. The burden of paying for a more generous care funding system in England over the next few decades would therefore fall on younger – frequently indebted – cohorts, rather than older cohorts, who collectively possess significant, housing wealth, and would be the ones to more directly benefit.[14] Such concerns have grown in the wake of higher rates of unemployment among young people, the increase in caps on university tuition fees and the continued difficulty of many young people in getting on the 'housing ladder'.

What will be the role of general taxation in funding care in future?

Given the limited options available to policymakers to raise new funding just to fund the current system in future - explored in subsequent sections - it appears inevitable that more money will have to be found for the care system in England out of general taxation.

Ultimately, this means spending on care and support may have to take precedence over other areas, such as education, transport, defence, etc.

3.2 The NHS

Could the money required by an improved care funding system come from the NHS?

Resources could be transferred from the NHS in two ways:

- Transfers directly from NHS budgets to local authority social care;
- Saving money through reforming service design, such as integrating health and social care services.

Why would money be transferred from the NHS to social care?

Public spending on the NHS – around £105 billion each year for the whole of the UK - dwarfs spending on disability benefits and local authority funded social care.

This has led some commentators to question whether more money could be directed to public spending on care and support by transferring resources from the NHS.

Behind such arguments rests the observation that if local authority social care spending is inadequate, this may result in higher costs for the NHS. For example:

- If appropriate preventative interventions - such as home adaptations for older people vulnerable to falls - are not in place, then the ultimate 'upstream' cost to the NHS may be higher;
- If older people cannot leave hospital because appropriate care and support services are not available – sometimes called 'bed-blocking' - this will result in significant extra costs to the NHS.

In short, the adequacy of public spending on care and support determines related costs for the NHS. Given this dependency, it has been suggested that the NHS should be required to contribute the extra resources to meet rising demand for social care, because it is the NHS that will ultimately 'pay the bill' if necessary resources are not found.

However, this viewpoint is also subject to counter-arguments, in particular, that it ignores other cost pressures on the NHS over coming decades associated with rising demand among those in the final years of their life, and rising unit costs of healthcare that result from technology and pharmaceutical advancements.

In short, simply taking money from the NHS to address the care funding gap merely creates a funding gap elsewhere.

Redesigning services to reduce costs

Another way in which commentators argue funding could be derived from the NHS for the care and support system in England is redesigning services, for example, through the implementation of more efficient, 'integrated' models of health and social care, with the money saved transferred to social care budgets.

Integrated care can take different forms, such as joint-working between health and care services, and merged budgets used to commission health and care services directly.

However, the integrated care agenda has been ongoing for at least 40 years, and the operational and efficiency savings identified by proponents have never fully been realised in practice. This arguably reflects some intractable dilemmas confronting the implementation of integrated care. For example, merging health and care budgets typically risks acute (hospital) care draining resources from social care. Cultural differences between health and social care organisations are also important.[15]

Estimating precisely the savings that could be achieved through health and social care integration has proved extremely difficult, and it is therefore important not to overstate these potential savings.

For example, the Audit Commission recently estimated that primary care trusts could save about £132 million a year if all those areas with high emergency admissions (given their population's characteristics), reduced activity to match the current national average through better prevention, care and support.[16] Although £132 million represents a substantial amount of money, it is small compared to the resources required by the care and support system to adapt to rising demand.

As such, although some of the new funding required by the social care system in England could be met through applying integrated care models, it would be wholly misleading – and irresponsible - to suggest that the care funding challenge in England can be met principally through savings arising from integrating health and social care.

In addition, from the point of view of policymakers seeking to evaluate different funding options, there is deep uncertainty around precisely how much 'saving' could be secured through redesigning services, in addition to the potential transition costs or upfront investment required to achieve greater integration of health and social care.

3.3 Reallocating Spending on Care and Support

Could resources be found by reallocating resources within current public spending on care?

There are three main ways in which this could be done:

- Means testing entitlement to Attendance Allowance;
- Councils including the value of people's homes as 'assessable wealth' for means testing for domiciliary care;
- 'Spending better' on social care – for example, on prevention – in a way that reduces demand.

Why restrict entitlement to Attendance Allowance?

Attendance Allowance (AA) is a universal, non-means tested benefit for people who require care that can be claimed by those over the age of 65.

In February 2011, there were 748,350 higher rate (£73.60 per week) recipients of AA in England, and 604,050 people receiving the lower rate (£49.30 per week). (Source: DWP). An estimated cost to the Exchequer would be £4.4 billion.

Some commentators have consistently argued that in the context of rising demand for care and support, disability benefits - in particular, Attendance Allowance – are no longer tenable in their current form, because they are paid to some individuals with high levels of wealth or income. In short, in the context of increasing pressure on public spending, resources should be targeted at those with highest need proportional to means, and in this context, universal disability benefits for wealthier older people should become means tested

Nevertheless, there are strong reasons to maintain Attendance Allowance in its current form, especially given growing rationing of local authority support.[17] Some academic evidence has suggested that recipients of Attendance Allowance are anyway more typically among lower-income groups.[18] Previous analysis from the Strategic Society Centre explored how revenue could effectively be derived through making the AA and care systems work better together, rather than simply just transferring resources from the former to the latter.

How much money could be derived from Attendance Allowance?

There are two main ways in which resources could be transferred out of public spending on AA: means testing; and, freezing its value proportional to inflation.

In relation to means testing, the King's Fund and PSSRU have calculated how much would be released from public expenditure on AA if in future only recipients of Pension Credit were allowed to begin claiming it, while nevertheless continuing to pay AA to existing claimants.[19]

£ billion	**2010/11**	**2015/16**	**2020/21**	**2025/26**
AA	-	4.17	4.41	5.13
Means tested AA	-	3.35	2.37	2.18
Savings	**-**	**0.82**	**2.04**	**2.95**

Revenue from phased means testing of Attendance Allowance, up to 2025 (2010 prices)

By 2025, nearly £3 billion could be derived from means testing AA. Another option – not explored here – would be to means test just higher rate AA.

However, it is important to note that there are multiple issues and challenges associated with means testing – such as non-take up of means tested benefits and government plans to phase out Pension Credit – and these are explored in Appendix 3.

How much money could be derived by freezing Attendance Allowance?

The total cost of AA in England for the 2010-11 financial year was £4.4 billion. If this spending was frozen in real terms and did not increase with inflation – assumed to be 2% - then the following savings would be realised up to 2025-26.

£ billion	**2010/11**	**2015/16**	**2020/21**	**2025/26**
AA	4.41	3.99	3.62	3.28
Released resources	**0**	**0.42**	**0.79**	**1.13**

How could money be released by changing the means testing rules applied for domiciliary care?

Various commentators, such as the Dilnot Commission on Funding of Care and Support, have argued that one potential way in which 'new' money may be derived for the social care system is changing means testing rules on domiciliary care.[20]

At present, the value of someone's home is not classified as 'assessable wealth' in the means test for domiciliary care applied by local authorities in England. As such, individuals can be entitled to substantial amounts of public support for the costs of care despite owning valuable properties.

This can result in outcomes that some stakeholders feel are anomalous, and even inequitable. For example:

- A woman aged 85 lives alone in a home worth £750,000, but has a very low income and little liquid savings. Under current rules, the value of her home would not be taken account of in the local authority means test – it would not be classed as 'assessable capital' – and she could be entitled to free care in her home, despite her considerable wealth.
- Two 80-year old men have identical care needs, and identical levels of income and wealth. However, one lives in residential care and must pay for his care 'out-of-pocket' at great personal expense until he only has £23,250 in capital remaining. The other is able to live at home, and despite the considerable value of his home, receives care and support for free because his income is low and the value of his house is not included in the means test.

Estimating how much might be raised by councils including the value of people's homes (for people who live alone) in the means test for domiciliary care is difficult, and depends significantly on the precise design of new rules.

Projections by the PSSRU estimated that if people's homes were included in the current means tests for domiciliary care, the number of council-funded home care users would be 145,000 in 2010 and 190,000 in 2030 under this scenario as against 285,000 in 2010 and 485,000 in 2030 under the current system. This would represent a saving to social services relative to the current funding system of some £1.2 billion in 2010 rising to some £3.4 billion in 2032 at constant 2010 prices.[21]

Would there be problems in changing the rules on housing wealth in means tests for domiciliary care?

Changing the council means test for domiciliary care in this way would represent a major and complex change in the English social care system. In particular, policymakers would have to consider carefully:

- Whether to 'grandfather' the system, such that new rules only applied to individuals applying for local authority support for the first-time. This would ensure there were 'no losers' among existing care users, but would also slow the release of new resources considerably.
- Options for individuals with limited savings and income to spend on care who would nevertheless be disqualified from local authority support on account of their housing wealth. As noted by the PSSRU, such individuals would require access to mechanisms to 'spend down' some of their housing wealth, such as equity release products or local authority 'deferred payment schemes'.[22] Policymakers would need to scrutinise these options carefully to ensure they were effective and reliable, such that elderly debt-averse individuals with care needs did not opt to go without care rather than take on debt. Rules would also have be put on place for the charging of interest in relation to such schemes.

Given such issues, it is worth noting that the Dilnot Commission on Funding of Care and Support recommendations for changing domiciliary means testing rules were conditional on the operation of the 'capped cost' model in England. However, the operation of the 'capped cost' model would also reduce the revenue that would be raised from such a change to current rules applied in the domiciliary means test.

How could money be 'better spent' in the social care system?

Across social care policy, various ideas and strategies have been developed to improve how resources on care and support are spent, in such a way that reduces demand or reduces the costs of the support that individuals need in order to live the life they want to lead. The Department of Health has itself led the way in encouraging councils to improve value for money.[23] Various changes can be identified, such as:

- New models of supported housing, such as 'Extra care';
- Telecare, which enables individuals in their own home for longer;
- Preventative schemes, such as the DWP's Partnerships for Older People Projects ('POPPs') scheme.

Multiple pilots of different schemes have been able to identify real savings, for example, the use of telecare to reduce hospital bed-days.

As with models of health and social care integration, for policymakers the key challenge will be to realise such savings, and to assess how much such savings can be 'banked' at a national level as a contribution toward the care funding gap in England.

3.4 Universal Benefits

Some commentators have consistently argued that those who will benefit from improved funding for care and support in England – typically, older people with resources – should also shoulder some of the cost.

One way of doing this would be to reduce spending on universal benefits for older people:

- Winter Fuel Payments;
- Free TV licenses for the over-75s;
- Concessionary travel (free bus passes);
- State Pension.

It should be emphasised from the outset that these options are explored here in order to explore the revenue they would provide, and their inclusion *should not be viewed as support for any of the potential changes examined.*

In addition, it is important to note from the outset potential unintended costs of restricting entitlement or spending on these benefits, which may in practice offset any extra potential revenue, for example, the consequences of older people failing to heat their home adequately in winter. Indeed, it can be argued that universal benefits such as subsidised travel and free TV licenses are in fact an effective form of prevention of care need that should themselves be seen as a form of public spending on care.

Finally, it should be noted that mean testing universal benefits would require using the existing means tested Pension Credit system, and this would create a number of issues for policymakers – in particular, the low take-up rate of Pension Credit – and these are set out in the Appendix. The government has also committed itself to a 'Single-Tier State Pension', which would eventually result in the phasing out of Pension Credit, and the means testing infrastructure it uses.

How much money could be derived from Winter Fuel Payments?

The number of households who received Winter Fuel Payments in England during 2010 was 7,896,760 (Source: DWP). The cost of Winter Fuel Payments previously has been estimated at £2-2.7 billion. However, levels of Winter Fuel Payment were lowered in the March 2011 Budget, which will see households where the oldest person is aged between 60 and 80 receiving £200 (instead of £300), and those where the older person is aged 80 or over receiving £300 (instead of £400).

In the absence of data for the cost of Winter Fuel Payments at the new levels, a total cost for England is assumed of £1.7 billion.

If Winter Fuel Payments were only paid to recipients of means tested Pension Credit in England, this would reduce expenditure from £1.7 billion to £0.37 billion, saving around £1.3 billion in 2010-11 terms.

2010-2011 prices	**2010/11**	**2015/16**	**2020/21**	**2025/26**
Pension Credit recipients (millions)	2.4	2.2	1.9	1.9
WFP (£ billions)	1.7	1.56	1.35	1.35
Means tested WFP (£ billions)	0.37	0.34	0.3	0.3
Saving (£ billions)	**1.33**	**1.22**	**1.05**	**1.05**

Revenue from means testing Winter Fuel Payments up to 2025 (2010 prices)

(£1 billion)

If we assume Winter Fuel Payments in England cost £1.7 billion in 2010, and inflation averages 2% over the next 15 years, the revenue that could be released from freezing the value of Winter Fuel Payments would be as follows:

	2010/11	2015/16	2020/21	2025/26
	1.7	1.54	1.39	1.26
Saving (£ billions)	-	**0.16**	**0.31**	**0.44**

However, it is worth noting that although research suggests that claimants spend 41% of the value of Winter Fuel Payments on fuel,[24] Winter Fuel Payments have been unsuccessful in reducing the number of 'excess winter deaths' in England. According to the Office for National Statistics, there were an estimated 25,700 excess winter deaths in England and Wales in 2010/11, virtually unchanged from the previous winter.[25] More widely, academic projections suggest the number of people in fuel poverty will increase in future.[26] As such, there are compelling alternative uses for public spending on Winter Fuel Payments, and policymakers would need to evaluate carefully the benefits of transferring this expenditure to spending on care and support.

How much revenue could be derived from free TV licenses for the over-75s?

Public expenditure on TV licenses for over-75s in England was £461.2 million in 2009-10 (Source: DWP).

Although it may be possible to means test the availability of free TV-licenses for the over-75s, such a move would likely only release around £300 million.

The government may consider this to be a relatively small amount in the context of the resources required by the care system, problems associated with means testing, as well as the potential public backlash that may result from restricting a relatively 'emblematic' entitlement.

How much revenue could be derived from restricting concessionary travel for older people?

Individuals aged above 60 in England may be entitled to concessionary travel, funded by their local authority.

The estimated cost to central and local government for local bus services and concessionary travel in England across all age groups is £1 billion.[27]

However, this amount includes concessionary travel for children and students. If it is assumed that 50% of this cost represents concessionary travel for older people, cutting this entitlement would raise around £500 million. A rough estimate of the money released from that means testing concessionary travel for older people would be around 80% of current expenditure, i.e. £400 million.

Given the cost of concessionary travel for older people is determined not just by the number of older people, but by the costs of providing travel services and the number of journeys older people make, it would not be possible to 'freeze' expenditure on it, and this option is not therefore considered

How could revenue be derived from the State Pension?

In Budget 2012, the Government announced it would commit to ensuring the State Pension age is increased in future to take into account increases in longevity. If this results in increases to the State Pension Age that are faster than currently planned, the revenue saved through reduced expenditure on the State Pension in future could be directed to the care and support system. Indeed, ring-fencing such a transfer may make increases to the State Pension Age more acceptable to the public.

3.5 New Taxation

The government could raise new taxation to fund the social care system over the next 15 years.

As with universal benefits, commentators have argued that if a reformed care and support system in England benefits wealthier older cohorts, then wealthier older cohorts should also 'pay' for such changes. Given the wealth of older cohorts mainly comprises the value of their homes, property wealth has therefore particularly featured in analysis of new taxation to fund care and support in England.

How much could be directed into the social care system through a new tax on estates?

In 2008-09, only around 6% of estates in the UK were subject to inheritance tax (IHT), at a rate of 40% on the value of estates over £312,000.

Some stakeholders have suggested that more funding for the English social care system could be achieved by levying a new hypothecated inheritance tax (IHT), or 'care duty', with a much lower threshold in order to 'capture' a far greater proportion of estates. Various pros and cons can be identified for this proposal.[28]

In the context of debate on funding care in England, it remains unclear whether a new inheritance tax would be levied for this purpose in England only or across the UK. The revenue from any new IHT would also depend on the number of people dying in a year and their wealth, which principally comprises property wealth.

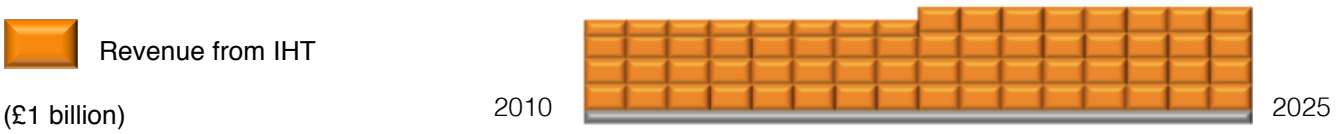
However, any new tax always changes behaviour. A new IHT threshold – for example, 13% of the value of estates above a level of £20,000 – may result in large numbers of households moving wealth around to minimise exposure to the tax in ways that would be impossible for HMRC to police, thereby reducing the revenue it yields. As such, a new IHT threshold of 5-10% may be more feasible.

How much revenue could be derived from a new IHT? Calculations by the Strategic Society Centre estimated that a new 5% IHT on estates in the UK worth more than £25,000 would have yielded just over £3.085 billion in 2007-08.[29] Adjusting for inflation, it can be assumed that a 5% IHT levied in 2010/11 would have raised around £3.4 billion. Given demographic and wealth profiles among the older population, it is reasonable to assume that over the next 15 years, this amount would increase reflecting trends in property prices and tenure.

- 5% IHT on estates above £25,000 (2010-11 prices)

£ billion (UK)	**2010/11**	**2015/16**	**2020/21**	**2025/26**
IHT 5%	3.4	3.6	3.8	4.0

Revenue from a 5% IHT on estates above £25,000 (2010 prices)



How much could be raised by applying a 'charge' to estates?

As an alternative to IHT – and to ensure that families were not confronted with an IHT bill that far exceeded the 'insurance value' of the new entitlement to publicly funded support - the value of older people's homes could effectively be taxed through the imposition of a flat-rate 'charge'.

Previous estimates by the Strategic Society Centre show a £20,000 charge on estates worth more than £40,000 would have yielded around £4.5 billion in revenue in 2007-08. However, the distributional effects are significant. Estates worth between £50,000 and £100,000 would see at least 20% of the value of the estate swallowed up by the charge, in contrast, for example, to 8% of the value of estates worth between £200,000 and £300,000.

Adjusting for inflation, such a charge would have raised around £4.8 billion in 2010/11. Given demographic and wealth profiles among the older population, it is reasonable to assume that over the next 15 years, this amount would increase reflecting trends in property prices and tenure.

£ billion	**2010/11**	**2015/16**	**2020/21**	**2025/26**
£20,000 charge	4.8	5.0	5.2	5.4

How much could be raised through a 'charge + cap' on estates?

A further alternative to a change to IHT thresholds or estate charge would be a 'charge + cap', in which a flat-rate charge is applied to people's estates, but in order to address distributional issues, a 'cap' is placed on the proportion of people's estates that could be paid toward it.

For example, this could take the form of a £20,000 charge on the value of estates above the level of £40,000 - with a 20% cap on the percentage of the estate taken as a charge, and would have yielded around £4.3 billion in 2007/08.

£ billion	**2010/11**	**2015/16**	**2020/21**	**2025/26**
£20,000 charge	4.7	4.9	5.1	5.3

Revenue from a 'charge + cap' on estate up to 2025 (2010 prices)

Comment

Although changes to IHT thresholds have featured heavily in policy debate on how to fund care in England, it is important to note that a new compulsory scheme designed to capture the value of older people's property wealth for the care system could be designed in multiple different ways, relating to labelling, incidence, thresholds and ring-fencing. Such design choices may go some way to offsetting the high levels of controversy that typically surround any proposed changes to IHT thresholds.

How much could be raised through applying capital gains after death?

Capital gains tax (CGT) does not apply on death, but could be applied using existing rules that exclude ISAs, bank accounts and primary residences. Calculations by the Institute for Fiscal Studies suggest this would raise around £670 million each year.[30]

How much could be raised through applying capital gains tax on primary home sales after death?

Primary homes – people's main owned residence - are not subject to capital gains tax (CGT); wealth accruing to owners through rising property prices is never taxed, except through a small proportion that is captured by current inheritance tax.

Of the £61.4 billion left in estates during 2008-09, around £30 billion comprised the value of UK residential buildings. Of 272,000 estates, 168,136 included residential property wealth, the average gross value of which was £178,230.[31]

As an alternative to changing IHT thresholds (and thereby penalizing savers), the government could levy capital gains tax on the value of primary homes sold after death, at the CGT rate of 18%.

If it is assumed that of the £30 billion of property wealth left at death, around 85% represents primary homes, and that owners had experienced on average a 40% increase in value between purchase and death, applying a CGT of 18% would yield around £1.8 billion per year.

£ billion	**2010/11**	**2015/16**	**2020/21**	**2025/26**
CGT on primary homes after death	1.8	2	2.2	2.4

However, changing CGT rules in this way may encourage individuals to simply move house in old age, thereby

banking the capital gain of their home and avoiding CGT after death.

What revenue would be raised if the over-60s had to pay National Insurance Contributions (NICs)?

At present, individuals over the State Pension Age with employed or self-employed income do not pay National Insurance Contributions (NICs).

Using the 2007-08 Survey of Personal Incomes and OBR assumptions on estimated changes in people's behavior, HM Treasury has estimated that the introduction of employee NICs contributions for this age group would raise around £500m in revenue for 2011/12.

The future revenue that would be raised from older workers paying NICS would depend on multiple factors such as changes to the State Pension Age, trends in labour market participation among older workers, and the state of the economy.

Revenue from NICs for over-60s

It is also important to note that compelling older workers to pay NICs, thereby reducing the financial returns from working past retirement age, would contradict the government aim of encouraging individuals to work longer.

Could revenue be raised by reducing the value of the annual pension 'tax-free allowance'?

Individuals making contributions to a private pension do so before their income has been subject to income tax.

The Government announced in October 2010 that from 2011-12 the annual allowance for tax-privileged pension saving will be £50,000 and that from April 2012 the 'lifetime allowance' will be £1.5 million. Taken together, the changes are projected to generate around £4 billion annually to the Exchequer. A threshold of £50,000 was set because only around 100,000 individuals currently have annual pension contributions above £50,000 – around 80 per cent of whom are on incomes above £100,000.[32]

As such, the personal tax-free allowance has already been heavily restricted.

Nevertheless, one proposal put forward for raising revenue for the social care system would be to lower the annual allowance even further from £50,000 to £30,000. Previous analysis by HM Treasury analysis has estimated that this would generate around £1 billion per year.[33]

A working estimate for the purposes of this report would therefore be £1 billion of extra revenue that could be generated by lowering the annual allowance to £30,000 per year. However, it should be noted that as a form of tax increase, this would affect working-age individuals only, and younger workers – who have longer to make pension contributions – the most. Nevertheless, since only high-income individuals actually make annual pension contributions of £30-50,000, the incidence of the tax would fall on higher-income individuals.

3.6 Pre-funded Insurance

Some commentators have suggested that the care funding-gap could be addressed through individuals purchasing pre-funded care insurance from private insurance companies.

At present, there is no pre-funded insurance market for social care in the UK: the last provider of such insurance exited the market in 2010 citing a lack of demand. Indeed, multiple, severe demand-side barriers can be identified for the pre-funded long-term care insurance market, some specific to England.[34]

However, the market also suffers significant supply-side barriers, in particular, the difficulties that insurance companies have in pricing products given 'unknowable' uncertainty around future patterns of claims that individuals could make on products.

If pre-funded insurance products for care were available, what would be their likely take-up and what revenue would this bring into the social care system?

Given the difficulties described above, previous analysis from the Strategic Society Centre explored potential take-up of the most likely pre-funded insurance product for care: 'critical illness' products that pay out a fixed amount – e.g. £35,000 - triggered by a policyholder experiencing a standardised measure of disability, for example, three Activities of Daily Living (ADL) failures.[35] To estimate the likely take-up of such products, analysis from the Centre deployed the following assumptions:

- The premium for such a product is £10,000 reflecting a one in three/four chance of experiencing the defined level of disability required to make a claim on the insurance;
- Nobody would spend more than one-third of their liquid saving and wealth on insuring themselves, i.e. nobody insures when it is not in their actuarial interest to do so;
- Individuals would not purchase insurance when still in employment, given the incentives (tax-relief and employer contributions) to make contributions to a pension instead.

Given these assumptions, most purchases of any pre-funded care insurance products introduced in the future would likely be around the point of retirement. What then would be the likely take-up of pre-funded care insurance in the future?

In 2012, around 716,800 people will turn 65.[36] Around 25% of the 65-74 age group has £60,000 in household liquid financial wealth.

Thus, it can be assumed that one quarter of the 716,800 individuals retiring in 2012 have sufficient liquid wealth such that they could consider buying pre-funded long-term care insurance for £10,000 for themselves and their partner.

This amounts to a potential 'target market' of around 179,200 people each year.

If an optimistic assumption is made that the take-up rate among the target market is 25%, this amounts to around 44,800 individuals, or 6.25% of new retirees.

For the sake of analysis, we can assume that if such products were put on sale in 2015, they would immediately reach a 25% take-up level of this potential market, and that the average age of claiming on a product would be 75, i.e. 10 years after purchase, and that one third of 44,800 individuals would claim each year – around 15,000 people, receiving £35,000.

On this basis, it is possible to project future revenue for the social care system coming from pre-funded long-term care insurance.

£ billion	**2010/11**	**2015/16**	**2020/21**	**2025/26**
Pre-funded insurance - £35,000 capped pay-out	0	0	0.25	0.52

Revenue from pre-funded insurance up to 2025 (2010 prices)

Comment

For policymakers looking at the role of pre-funded insurance in funding care in England, the key issues are take-up and timing: what revenue will be brought into the care system, and when?

The assumptions used in the above analysis are optimistic, in particular the assumption that take-up of pre-funded care insurance would move immediately from zero to 45,000 products sold per year. Timing is important because even if such a market were to develop quickly, there would nevertheless be a time delay between when products were purchased and when individuals began to claim on the products, thereby bringing new revenue into the social care system.

3.7 Disability-linked Annuities

Could disability-linked annuities play a greater role in funding care?

Individuals retiring with a defined-contribution (DC) pension scheme – roughly half of workers - use the value of their accumulated pension savings to purchase an 'annuity', which pays out a regular income for the rest of their life, whether they die after one year or 40 years.

Disability-linked annuities (DLAs) are a type of annuity, which pays out a higher income when someone experiences a defined level of disability, for example, three ADL failures.

Some stakeholders have tipped DLAs as being a potential source of revenue for the social care system.

How much revenue could disability-linked annuities bring into the social care system?

As with pre-funded care insurance, providers of DLAs would struggle with uncertainty around future trends in disability and longevity, and how long such products would have to pay out for.

As such, it makes sense to model a capped amount of increased income that could be paid out from an annuity.

It is possible to estimate the size of a potential DLA market by incorporating some of the same assumptions for pre-funded insurance set out above.

How many people might purchase a DLA?

It can be assumed that someone has to have a pension pot of at least £70,000 before allocating £20,000 of it to providing protection against care costs for two people.

Given available data on the average size of pots used to purchase annuities - and assuming that those already purchasing 'enhanced' or 'impaired' annuities would not purchase DLAs - this means that only 8% of annuity purchases would represent potential DLA purchases, i.e. 8% of 'investment linked' and 'standard' annuity purchases, which is 8% of 419,047 = 33,523 per year.[37]

Of a potential target market of 33,523, what would be the likely take-up rate? Various demand-side factors are important here. For example:

- Annuitants typically make 'bad choices', frequently simply choosing the annuity that pays the highest immediate income;
- Individuals discount the risk of needing care;
- Wealthier individuals may opt to 'gamble', e.g. by planning on using pension income to fund any future care needs, rather than obtaining insurance protection against care costs;
- Individuals may prefer – entirely sensibly – to choose an annuity that protects against the effect of inflation, rather than against the risk of future care costs.

As such, a reasonable assumed take-up rate among this potential target market of 33,523 would be 25%, which represents 8,381 DLA sales per year for 16,762 lives assured.

For the sake of analysis, we can assume that if such products were put on sale in 2015, they would immediately reach the 25% take-up level of the potential market described above, and that the average age of claiming on a product would be 75.

How much revenue could disability-linked annuities direct into the social care system?

On the basis of the above assumptions, the revenue that would be directed into the social care system from disability-linked annuities would be as follows:

£ billion	**2010/11**	**2015/16**	**2020/21**	**2025/26**
Disability-linked annuities - £35,000 capped pay-out	0	0.01	0.02	0.3

By 2025, around £300 million might be brought into the social care system through the use of disability-linked annuities. As with pre-funded insurance, the gap between purchase and claim means there would be a significant delay before revenue was realised for spending on care.

3.8 National Care Fund

Many countries with ageing populations, such as Germany and Japan, have remodelled their care funding systems around state-sponsored insurance schemes.

Such an approach is seen as overcoming the problems of relying on voluntary private insurance, but nevertheless provides a ring-fenced, secure funding stream for care built around private contributions.

In the debate on long-term care funding in England, the most prominent proposal for a state-sponsored insurance scheme for care was the proposal for a *National Care Fund*, which was first put forward by the current author in 2008 and subsequently updated extensively in 2011.[38]

How would a *National Care Fund* work?

The *National Care Fund* proposal was developed on the assumption that the current means tested social care system in England would not become more generous over time, and on that basis, a new structure was required to sit 'on top' of this framework, which would enable home-owning older households to use some of their housing wealth to provide protection against care costs.

The principal rationale and objective of the *National Care Fund* model is therefore to provide a mechanism – or 'vehicle' - for directing more money into the social care system from wealthier older cohorts. It is an institutional response to the political challenge of encouraging the older population to contribute some of their housing wealth to protect themselves against their future care costs.

The proposal for a *National Care Fund* included a flexible contribution mechanism: having made a commitment to join the Fund, individuals would be given the option of paying in an up-front lump-sum payment, instalments from income or as a charge on their estate. Participation in the *National Care Fund* would be voluntary, but could be made compulsory over time. 'Soft-compulsion' could be used to boost participation rates.

How much would it cost to join a *National Care Fund*?

As with any insurance scheme, the cost of premiums for a *National Care Fund* would depend on the benefits individuals received upon making a claim. The Fund could seek to cover a proportion of average care costs upon someone experiencing a defined level of disability. Alternatively, it could seek to 'cap' costs, by only making payments after a person has experienced a defined level of need for a certain amount of time.

In order to explore the model, it is possible to use proposed 'normative' levels of formal support for different levels of need, drawing upon the Department of Health's Fair Access to Care Services (FACs) criteria, which were developed by the King's Fund.[39] The 'normative' level of support is the level of support it is assumed a person requires, irrespective of their financial situation, and excludes the accommodation costs of residential care. The figures proposed by the analysis are as follows:

Normative levels of formal support under benchmark care packages [40]

Need level	**Mean level of support (£s per week)**
Low	10
Moderate	96
Substantial	151
Critical	229

(Source: Humphries R et al. (2010) *Securing Good Care for More People*, The King's Fund, London)

For the sake of analysis, the target amount for a weekly benefit payable by the *National Care Fund* to individuals entitled to make a claim, who would have experienced at least 3 ADL failures, could therefore be set at around £150 per week (although many individuals would also be entitled to claim Attendance Allowance).

On this basis, analysis by the Strategic Society Centre has derived that for £150 per week payable until death after experiencing three ADL failures, the cost of the premium would be £8000.[41] It is important to note that the *National Care Fund* would provide insurance against personal care costs, rather than the accommodation costs of residential care. Assessments for claims would be 'carer-blind', i.e. they would not take account of the availability of informal care.

What would be the likely take-up of a *National Care Fund*?

By enabling individuals to pay their premium using their property wealth, the number of individuals who would be able to afford to insure themselves would be substantially higher than for private sector pre-funded insurance.

In the 65-74 age-group, median household wealth is around £200,000 or £100,000 per person, excluding private pension wealth, but including property wealth.[42] As such, among individuals who reach State Pension Age each year – around 716,800 people – a large majority would be able to afford the insurance. In addition, take-up would likely be positively influenced by a simple, clear choice for individuals that a *National Care Fund* would provide.

It can therefore be assumed that 30% of individuals retiring sign up to participate in a *National Care Fund*, and that there is a ten-year delay before significant numbers would begin claiming on the Fund.

Existing academic projections from the Personal Social Services Research Unit suggest that the number of individuals aged 65+ with 3 or more ADL failures is around 1 million, with the number set to rise slightly over the next 25 years.[43] If it is assumed that around one third of individuals experience 3+ Activities of Daily Living (ADL) failures has participated in the *National Care Fund*, then these individuals would be entitled to £150 per week.

On this basis, the following projections of revenue for the social care system can be made:

£ billion	**2010/11**	**2015/16**	**2020/21**	**2025/26**
National Care Fund	0	0	1	2.6

By 2025, a *National Care Fund* would direct around £2.6 billion of new revenue into the social care system.

Revenue from a National Care Fund up to 2025 (2010 prices)

3.9 How to make the Funding Decision

What are the key factors that policymakers need to remember in making the 'funding decision'?

Society can afford a properly funded social care system in England

It is always important to remember that despite the significant cost of a properly funded care system in England, it is affordable to the state and to wider society. Ultimately, how much public expenditure is directed to care and support is a political decision.

It is also important to note that some of the main beneficiaries of a reformed long-term care funding system would include some of the wealthiest groups in society, for example, property-owning 'baby-boomers', suggesting that for the state and for households, the problem of long-term care funding is ultimately not one of resources. Rather, the problem derives from issues of perception, expectations and the choices of both households and politicians.

Various broad approaches can be identified

The options for the 'funding decision' set out in this section of the Roadmap can ultimately be reduced down to several broad approaches:

- Tax more;
- Reprioritise public spending from other areas;
- Target resources more, for example, by means testing existing support provided to wealthier households;
- 'Spend better', i.e. increase the effective resources available through efficiencies achieved by integrating health and social care services, or better integrating the Attendance Allowance system with the care system;
- Bring in new private contributions, for example, through the creation of a state-sponsored *National Care Fund*.

Each of these approaches will have to be evaluated by politicians for political feasibility, whether they are progressive, whether they are fair - for example, between the generations – and what revenue they would direct into the social care system.

Multiple strategies will have to be deployed

Even if more spending from general taxation is used to fund care and support in the context of population ageing, multiple funding options set out in this Roadmap are likely to have be deployed if a better, fairer system is to be achieved.

As such, the 'funding decision' is not about one option or another, but rather, about how much emphasis is given to multiple different options.

What happens if we do nothing?

If no reform of how care in England is funded occurs, the social care system would be left to compete for resources over the next decade with other areas of public expenditure such as health, education and transport.

In effect, this scenario would test the capacity of social care users and other stakeholders to lobby the government for increased public spending on care and support, in order to maintain entitlements in the face of rising demand.

It is impossible to reliably project what would happen to public spending on social care in England under this 'do nothing' scenario.

However, a reasonable estimate might be that of the £11.5 billion required by the system by 2025, compared to 2010, *just to stand still*, only £8.5 billion would be found. This reflects the limited ability of social care stakeholders to push for more funding for care, and the difficulties that social care confronts in achieving 'political

resonance' – previously documented by the Strategic Society Centre – not least arising from the fact that national politicians are able to shift responsibility for budget cuts to local councils.[44]

If only £8.5 billion more were found for spending on care and support by 2025, this would result in a significant worsening of problems identified in the current system such as unmet need, over-burdened family carers and downward pressure on quality.

But such an analysis is important because it highlights how much could be expected to be spent on care and support by 2025 out of general taxation, *in the absence of* the decisions on spending and on funding described in this Roadmap.

Thus, assuming that even on a 'do nothing' scenario, an extra £8.5 billion of public spending would have to be found up to 2025, what is the actual amount of *extra* spending required in addition to this amount to achieve a decent new partnership between individuals and the state for funding the costs of care?

In fact, as earlier sections exploring new 'partnerships' between individuals and the state showed – such as the 'capped cost' or 'Means test Plus' models – the difference between this 'do nothing' scenario and an improved partnership in 2025 is around £6 billion per year.

This equates to no more than 1.5% of public spending.

In effect, the political parties must come together to agree how to raise and spend around 1.5% of public spending in order to achieve fairer and better outcomes for some of the most vulnerable people in society. Not only is this amount small in the context of public spending, it is also small when set against other areas of public spending that benefit from political consensus, such as the NHS and education spending.

4. The Roadmap: Conclusion

This Roadmap has set out the options for addressing England's care crisis.

To move forward, the government must make two decisions:

- **The 'spending decision'**: What will the state spend on care and support in future, and how will this money be spent?
- **The 'funding decision'**: Where will the money come from to fund spending on care?

Ultimately, rising demand for care owing to population ageing represents a fundamental strategic challenge to policymakers, public services and wider society.

Meeting this challenge will mean ensuring that the right support is provided to those who need it, at the right time, paid for in a way that is fair to individuals, families and the state.

The difficult decisions and trade-offs for funding care and support set out in this Roadmap represent an historic adjustment that must be made in response to this new challenge.

What is needed to achieve reform?

This Roadmap has shown how rising demand for care associated with population ageing will mean the proportion of GDP spent on care and support by the state will have to increase, just to maintain the current inadequate system of entitlements and support.

But this Roadmap has also highlighted that there are positive choices that can be made that would result in a better, fairer system.

Making these positive choices must now be the priority of politicians.

However, making these choices will also require hard decisions and tough trade-offs about where the money will come from, and this can only be done with public support.

The government needs to have an honest conversation with the public about what sort of care system people want and how they want to pay for it.

This means making the public aware of the core truths of the care funding challenge: we are all living longer, we are all going to need more care and support, and we are all going to have to pay for it.

Appendices

A1. The ‘control dials’ for redesigning council support

In designing the shape of a new local authority system for funding care, what are the ‘control dials’ for policymakers to turn?

Multiple options for redesigning England’s care funding system have been proposed. Each represent different settings of the ‘control dials’ that policymakers can turn to change the level and form of local authority funding for care and support. What are these ‘control dials’?

Eligibility Threshold

The level of assessed need at which individuals become eligible to local authority support. At present, local authorities apply a scale of need called Fair Access to Care Services (FACS), which features four standardised levels of need: Low; Moderate; Substantial; and Critical. Most councils now set their eligibility thresholds at Substantial or Critical, although there is variation between areas in the interpretation of what needs constitutes Substantial or Critical need.

Assessable wealth

This refers to those types of income and wealth that local authorities will take account of when undertaking means tests. This will currently include the value of someone’s home (if no one else is living in it) for residential care, but not for care that someone receives at home.

In other words, rules of assessable wealth for local authority means tests determine what types of wealth are ‘protected’ because they are not taken account of in the means tests.

Lower Capital Limit

The level of assessable income and wealth below which councils will fund all personal care costs, minus any ‘livings costs’ paid by individuals in residential care. Currently, this is £14,250.

Upper Capital Limit

The level of assessable income and wealth, below which individuals pay subsidised charges for care services. This has remained at £23,25 for several years, despite above-trend levels of inflation in the economy.

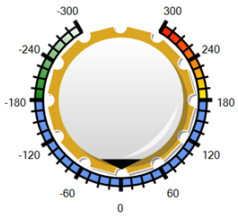
Percentage of assessed ‘care costs’ funded

This is the proportion of a person’s assessed care needs that will be funded by a local authority. At present, if someone has more than £23,250 in assessable wealth, the percentage funded by councils is 0%. However, under the ‘Partnership 33%’ proposal, this would be 33%. Under the Dilnot Commission’s ‘capped cost’ model, this would initially be zero, but would be 100% once a person has experienced accumulated assessed needs proportional to £35,000 of care. As such, the percentage of ‘care costs’ funded by the state can vary at different points in a person’s care ‘journey’.

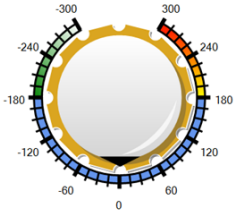
Using this control pad to design a new partnership between individuals and the state

By turning these dials, policymakers can come up with multiple different options for configuring the shape of state support for social care costs.

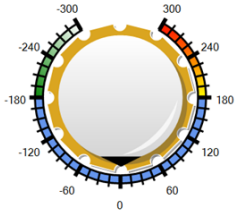
In between the current system and 'free personal care', many different configurations are possible.



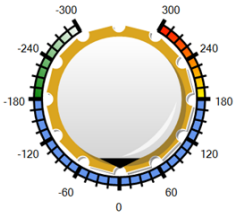
Eligibility threshold



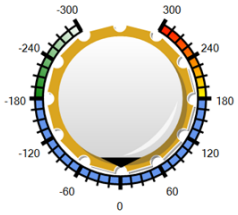
Assessable wealth



Upper Capital Limit



Percentage of assessed 'care costs' funded



Lower Capital Limit

For example, it is simple to imagine combining the 'Partnership' model and the 'capped cost' model, such that local authorities fund at least 20% of everyone's assessed care costs, but once a person's accumulated assessed costs reach £70,000, they would be entitled to receive 100% of their assessed costs from the local authority. This hybrid model would ensure everyone with qualifying needs received something from their council, but would still provide a 'cap' on notional costs.

A2. Trends in Public Spending on Care and Support

Public spending on social care for adults in the local authority system in England will grow over the next 15 years, if it is assumed that levels of spending 'per person' remain at the same level as today.

Adult social care expenditure in England
(2010/11 prices)

	2010/11	**2015/16**	**2020/21**	**2025/26**
Care costs				
Older people care	6.6	7.4	8.8	10.8
Young adults	5.9	6.3	7.4	8.6
Total care costs	**12.5**	**13.7**	**16.2**	**19.4**
Assessment and care management				
Older people	1.1	1.3	1.6	2.0
Younger adults	0.9	1.0	1.2	1.4
Total assessment and care management	2.0	2.3	2.8	3.4
Net social care	**14.5**	**16.0**	**19.0**	**22.8**
Extra cost (£ billion)	*-*	*+1.5*	*+4.5*	*+8.3*

Source: Commission on Funding of Care and Support (2011) *Fairer Care Funding Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support*

This table shows that just to maintain local authority social care spending at current levels, the government will have to spend an extra £8.3 billion per year by 2025.

Trends in Public Spending: Adult disability benefits in England

The key adult disability benefits are the 'care component' of Disability Living Allowance for older people and younger (working age) adults, as well as Attendance Allowance for older people.

To maintain these entitlements at current levels with the same eligibility criteria, public spending on disability benefits will have to increase by 2025.

Public Spending Adult Disability Benefits in England
(2010/11 prices)

	2010/11	**2015/16**	**2020/21**	**2025/26**
Older people	6.6	7.4	8.3	9.3
Younger adults	5.1	5.2	5.4	5.6
Total	**11.7**	**12.6**	**13.7**	**14.9**
Extra cost (£ billion)	*-*	*+0.9*	*+2*	*+3.2*

Source: Commission on Funding of Care and Support (2011) *Fairer Care Funding Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support*

By 2025, public spending on disability benefits for adults in England will have to increase by £3.2 billion per year to maintain current levels of support.

Public Spending on Care and Support: What will happen by 2025?

If disability benefits and local authority spending on social care and disability benefits are added together, it is possible to estimate how much public spending on care and support will have to increase if it is to maintain equivalent levels of support as today.

Current and Future Public Expenditure on Adult Care and Support in England
(£ billion, 2010/11 prices)

	2010/11	**2015/16**	**2020/21**	**2025/26**
Net social care	14.5	16.0	19.0	22.8
Disability benefits	11.7	12.6	13.7	14.9
Total	**26.2**	**28.6**	**32.7**	**37.7**
£ billion extra	-	+2.4	+6.5	+11.5

By 2025, an *extra* £11.5 billion of public spending will have to be directed to care and support, equivalent to around 2% of taxation revenue today. This is the cost of maintaining a system that many people already believe to be broken and inadequate.

A3. Issues in means testing universal benefits

In debate on how to fund social care, policymakers have explored whether public spending could be transferred from other types of public spending that currently go to those groups that would benefit from social care funding reform, in particular, older people.

In this way, social care funding reform would merely be 'switching' resources from one type of spending to another targeted at broadly the same group. As such, there would be fewer real 'winners' and 'losers', because many would be the same people.

Means testing Universal Benefits and Transfers to Older People

One proposed source of new revenue for the social care system would be to means test the availability of some universal (non-means tested) transfers and benefits to older people.

In order to do this, it is proposed that the current means testing system for older people used to allocate Pension Credit would be deployed.

At present, the Department for Work and Pensions (DWP) operates means tested Pension Credit for people in retirement, as a supplement to the State Pension of £102.15 for a single person, which is recognised as inadequate to live on.

It would be unfeasible and too expensive for universal benefits for older people, such as Winter Fuel Payments, to be means tested by a separate means testing system. Instead, such benefits would have to use data from the Pension Credit system to target means tested entitlements; in effect, 'piggybacking' on the Pension Credit system.

Current and estimated future numbers claiming Pension Credit in the United Kingdom – compared to the State Pension - are as follows:

Estimated Caseloads (millions) – UK	**2010/11**	**2015/16**	**2020/21**	**2025/26**
Basic State Pension	12.6	13.2	12.9	14.2
Pension Credit	2.8	2.5	2.2	2.2

Source: DWP

How many current and future claimants of Pension Credit live in England? Within the UK, the pension age population of Scotland is around 1.03 million, and 558,100 in Wales.

As such, a reasonable working estimate of pension age individuals in England is around 11 million, or 87% of the pensionable population in the UK. Carrying forward this assumption over the next 15 years, the number of individuals who will receive the Basic State Pension and means tested Pension Credit in England during this period can be estimated at:

Estimated Caseloads (millions) – England	**2010/11**	**2015/16**	**2020/21**	**2025/26**
Basic State Pension	11	11.5	11.2	12.4
Pension Credit	2.4	2.2	1.9	1.9
Pension Credit claimants as % BSP claimants	22	19	17	15

Using the Pension Credit System to Means test Universal Benefits for Older People

What are the pros and cons of using the Pension Credit system to means test universal benefits for older people?

The principal advantage is that benefits that are newly means tested would not require their own new means testing system. However, a number of disadvantages can be identified:

- Take-up of means tested Pension Credit

DWP estimates that take-up of Pension Credit among those entitled to it is between 62% and 73% overall.[45] As such, any currently universal benefit that was means tested would only go to between 62% and 73% of low-income eligible older people.

- Resentment

Means testing of Pension Credit is resented by older people, so any increase in the scope of means testing would likely be resisted.

- Retirement saving incentives

Any form of means testing in retirement undermines incentives to save for retirement; if individuals save, they effectively disqualify themselves from entitlements they would have otherwise received. Although the actual effect of retirement means testing on pension saving behaviour is unclear, the stated objective of DWP is that it must “pay to save”.

- Future abolition of Pension Credit

In Budget 2012, the government announced that it would introduce a single-tier state pension of around £140 per week, above the level of mean tested Pensions Credit.

However, the introduction of a Single Tier State Pension will take away the key means testing infrastructure used for Pension Credit, which would also be used for any means testing of older people’s universal benefits. As such, the introduction of the Single Tier State Pension means it is far from clear that mean testing of universal benefits would actually be feasible in practice.

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