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Reforming social care: options for funding

Policy response

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The Government is expected to publish a White Paper on the future of social care in 2012. The White Paper will set out the Government's response to the recommendations from the Law Commission on reform of adult social care legislation (Law Commission, 2011) and the Dilnot Commission review of funding for adult social care (Commission on Funding of Care and Support, 2011). There is a risk that reform of funding will be neglected: the forthcoming White Paper is expected to include proposals for the reform of adult social care following the Law Commission's report on modernising the legislative framework, but the Government has only committed itself to 'a progress report on funding reform' (Lansley, 2011). This paper examines the current level of funding of social care and the Dilnot Commission's recommendations and suggests ways of funding a fairer, more sustainable system of social care.

Key Points

- Social care funding is in urgent need of reform. Recent cuts to social care budgets have intensified an underlying mismatch between funding and demand, so that a growing number of people on low incomes are no longer eligible for state support. In addition, many people are forced to sell their homes to meet the costs of residential care.
- Without action, this situation is likely to worsen. Estimates produced for the Dilnot Commission suggest that even without reform, spending on social care will have to rise from £14.6 billion in 2010/11 to £23 billion by 2025/26.
- The Dilnot Commission proposals would extend more state funding to the less well-off, and offer some publicly funded care to everyone faced with very high costs of residential care. Implementing these would cost an additional £3.6 billion by 2025/26. The recommendations have received broad support across organisations that represent care users and providers.
- A better-funded social care system, which includes the Dilnot proposals, will require increased public spending on adult social care. There are various options for paying for this. In the short term, more funds could be made available from the NHS: primary care trusts (PCTs) are currently projecting an underspend of £1.5 billion in 2011/12. The Department of Health should consider using part of this for further transfers to social care.

- Redirecting some of the 2011/12 NHS surplus will not be enough on its own. Other potential sources of funding include: minimising the cost of the Dilnot recommendations by opting for the higher level of caps proposed; generating more productivity from existing social care services; and exploring options for reallocating elements of the health and welfare budgets to fund a reformed social care system.
- Social care spending accounts for around six per cent of the £140 billion a year of public spending on older people. It is not clear that the current mix of spending on social care, health and welfare payments for older people is optimal. The Government should consider shifting resources from the welfare payments currently received by better-off older people, to fund long-term reform of social care. It should also explore whether some of the health budget could be more efficiently spent on preventative social care.
- If the costs of social care cannot be met within the overall sum of state support to older people, some form of higher taxation may also need to be considered. This should be guided by principles of equity – between generations as well as between people with differing levels of income and wealth. In particular, the Government should explore options to direct the burden of any tax increases onto wealthier older people.
- The Government urgently needs to begin a dialogue with the public about how social care will be paid for in the future. Some progress has been made in discussing the principle of individuals contributing their own wealth and assets to pay for their own care. But there has been much less debate on the need for additional public funding.
- There will need to be a parallel focus on improving the quality of social care provision. It will be difficult to make the case for increased personal contributions to the public costs of care – whether delivered in the home or as residential care – if it is seen as being of poor quality and unable to treat people with dignity.

Introduction

A success story of the twentieth century – increased longevity – has created a challenge for the twenty-first: how best to meet the care needs of older adults. By 2030, more than one in ten of the population will be aged 75 or over; there will be 2.8 million more people in this age group than in 2008, representing a growth of 70 per cent (Office for National Statistics (ONS), 2011a). This increase will bring a rise in the conditions associated with old age that require both health and social care services: for example, the number of people living with dementia in the UK is expected to reach 1.4 million by 2040 (Knapp and others, 2007).

Formal support for carrying out personal care or domestic routines is known as social care. The current system, which was conceived in 1948, is widely considered to be underfunded, confusing and unfair. There are wide geographical variations in the services and financial support available. In all areas, the minority of people who need expensive care (usually in residential homes) are often required to contribute a large proportion of the costs.

> The current system is widely considered to be underfunded, confusing and unfair

Overall, the amount of money being spent on social care is comparatively small. In 2010/11, net spending on adult social care in England was £14.6 billion: this represents 1.16 per cent of gross domestic product (GDP). Just over half of spending on adult social care is spent meeting the needs of older people. The other key groups receiving state-funded support are working-age adults with physical or learning disabilities. Social care spending is also a small component of public spending on older people as a whole. In 2010/11, the state spent £140 billion on services and support for older people, but just six per cent of this was spent on social care. The NHS accounts for just over a third of overall spending on older people, with social security benefits (including the state pension and disability benefits) accounting for almost 60 per cent.

The resulting financial pressure on social care services has had an impact on quality and access. There is mounting concern about the declining quality and fragmentation of social care services, including those delivered in the home and in residential homes (Equality and Human Rights Commission (EHRC), 2011; Age UK, 2012). Reduced access to social care services also has an impact on the NHS. With an aging population, many social care service users are living with multiple long-term conditions, and their complex needs often span the care and cure sectors (Humphries and Curry, 2011). Financial pressure on social care services can result in unmet care needs, which could later result in pressure on health services in the form of avoidable admissions or unnecessarily long stays in hospital. An underfunded social care sector may also undermine attempts to integrate health and social care services.

These problems are not new. Over the last 15 years there have been a number of attempts to reform social care to address these concerns, including the Royal Commission on Long Term Care (Department of Health, 1999); the Wanless review (Wanless and others, 2006) and the previous government's White Paper *Building a National Care Service* (Department of Health, 2010a). This policy response offers

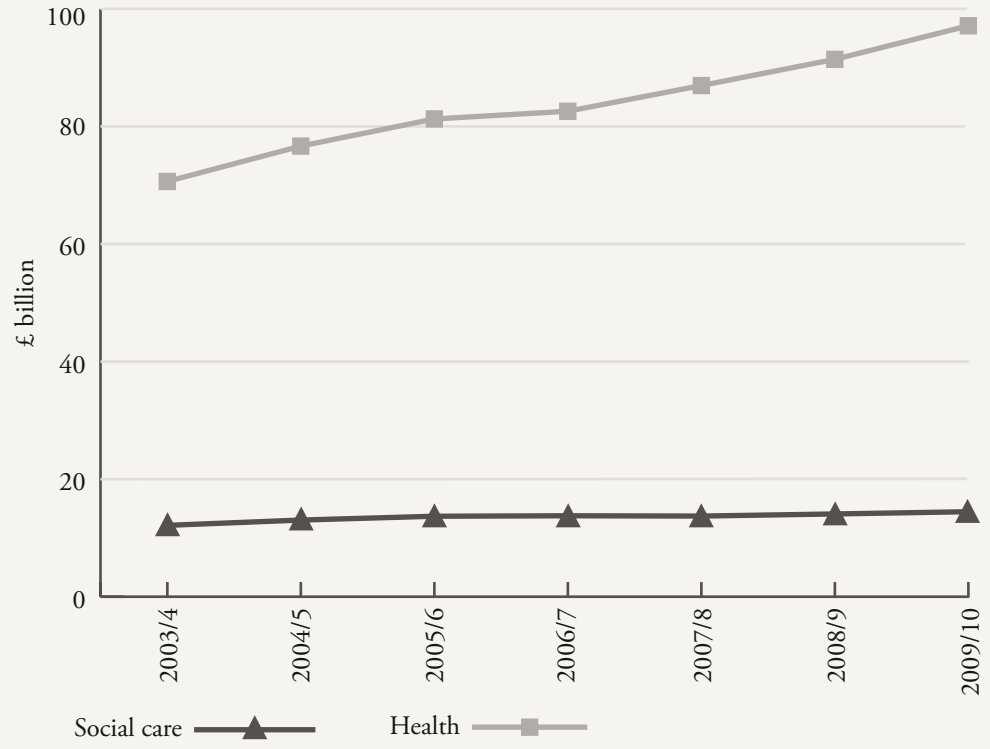
an analysis of the latest attempt to resolve the problem: the Dilnot Commission's recommendations to reform the funding of adult social care (Commission on Funding of Care and Support, 2011). The briefing draws on our knowledge of the interdependence of health and social care services, which forms an important element of our current and future work (Nuffield Trust, 2012). The paper starts with an analysis of the size of the funding gap and follows with an appraisal of the different options for bridging that gap from public funds.

How big is the funding gap in social care?

Recent trends in social care funding

Spending on social care has risen in the past decade, but at a much slower rate than health spending: Figure 1 shows the trend since 2003/04. Over the seven years since 2003, spending on social care in England increased by 19 per cent in real terms compared to 37.5 per cent for health care (HM Treasury, 2011; NHS Information Centre, 2011).

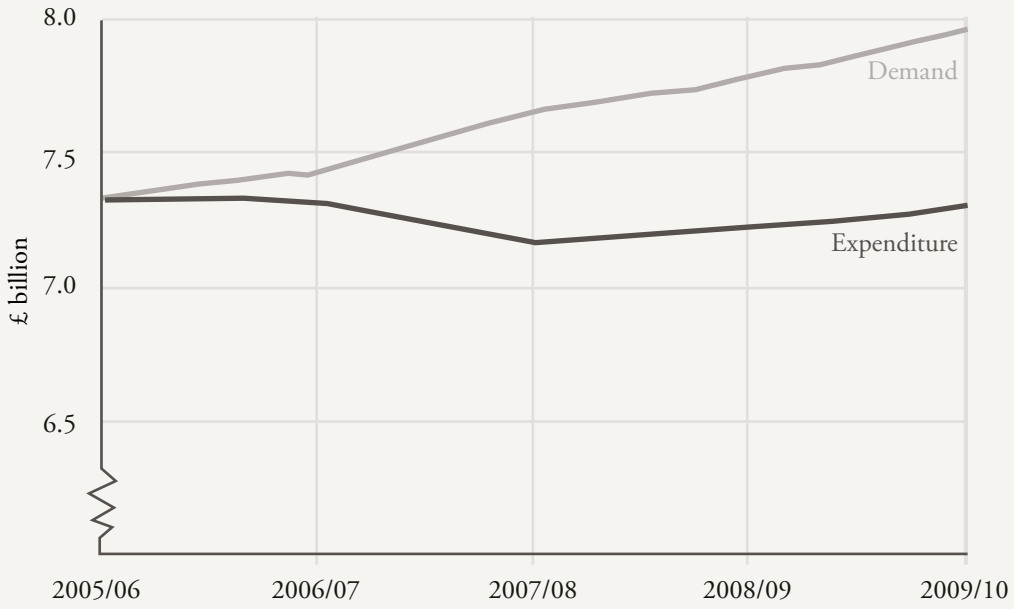
Figure 1: Real-terms spending on health and social care (England)



Source: HM Treasury, 2011; NHS Information Centre, 2011

Evidence suggests that even before the recent cuts, this rate of growth has been too slow to keep pace with the needs of older adults. The Dilnot Commission estimates that, over the last four years, demand has grown to around nine per cent higher than spending (Figure 2).

Figure 2: Expenditure and demand: older people's social care (2009/10 prices)



Source: Commission on Funding of Care and Support, 2011

Data for 2010/11 show that immediately before the 2010 Spending Review, social care budgets were already under pressure. Net spending on adult social care grew very slightly in cash terms, from £14,460 million in 2009/10 to £14,610 in 2010/11. But, after allowing for inflation, spending fell by 1.7 per cent across England in 2010/11 (NHS Information Centre, 2011; 2012).

> Most people with 'moderate' or 'low' care needs are not eligible for publicly funded support

Impact of the current spending cuts

This gap between demand and expenditure would have grown regardless of the current financial climate, but the spending cuts designed to reduce the public sector deficit are likely to have made the gap worse. Social care is funded from local authority budgets. The proportion allocated to social care depends on local priorities and is not 'ring-fenced' nationally. The 2010 Spending Review cut the allocations to local government in real terms. Overall local government spending on non-ring-fenced services (which includes social care but excludes schools, fire and the police) is projected to fall by 14 per cent in real terms by 2014/15 (House of Commons Health Committee, 2012).

The Government has attempted to mitigate this fall by directing additional funds towards social care, but it is unlikely to be enough. The 2010 Spending Review earmarked £7.2 billion of additional funding for social care spread across four years from April 2011. In 2014/15 the additional funding will comprise:

- £1 billion in new grant funding from central government for social care (allocated to local authorities but not ring-fenced)
- £1 billion from the NHS to support social care.

The Dilnot Commission argues that as a result of the reductions in overall allocations to local authorities, not all of the money intended for social care in the spending review has found its way into social care budgets. The Government's view is that local authorities will be able to maintain social care services up to 2014/15 within current allocations through efficiency savings. Though the Government does recognise that there is some unmet need, it argues that this is difficult to quantify (House of Commons Health Committee, 2012).

Consequences for social care

Local authorities can manage the financial pressure in three main ways: improving the productivity of social care services; restricting access to care; or reducing the quality of care.

Data on productivity are very limited. Over the last five years, the shift from residential care to day and domiciliary services has continued – by 2010/11, spending on these services had increased to 46 per cent of total spending on adult care needs, compared with 41 per cent five years earlier (NHS Information Centre, 2012). But research suggests that in aggregate, the productivity of adult social care services has fallen over recent years. The official estimates of public sector productivity (which do not adjust for any changes in quality) show that the productivity of adult social care services fell by an average of 1.5 per cent a year between 1997 and 2008 (Phelps and others, 2010). As spending has come under pressure, there is evidence of unit costs falling in real terms. In 2010/11 the average cost of an adult in residential care fell slightly in real terms (by less than one per cent). The average cost for someone receiving care at home fell more sharply; by six per cent in real terms compared with 2009/10. However, in 2010/11 overall unit costs did not fall as much as the reduction in spending. The changing mix of adults being supported by the social care system may be an important factor – as a share of the total social care budget, spending on adults with learning disabilities who are under 65 has risen as spending on older people has been falling (NHS Information Centre, 2012).

Research by The King's Fund suggests that, in order to address the potential funding gap over the spending review period, productivity would need to be transformed, requiring efficiency savings of up to 3.5 per cent a year (Humphries, 2011). Analysis by the Audit Commission shows significant variations in costs between local authorities, suggesting there is scope to improve productivity. It finds that "councils can make cash-releasing savings by looking to provide the same or similar services at lower cost". Meeting this challenge requires transformational change; the Audit Commission notes that such change is difficult to achieve and that progress to date has been slow (Audit Commission, 2011).

As increasing productivity alone is unlikely to provide a solution, local authorities have systematically been reducing access to care. Local authorities use the Fair Access to Care Services (FACS) system for determining eligibility to receive state-funded social care (see Box 1). In 2005/06, 62 per cent of local authorities had restricted their eligibility threshold for publicly funded social care to 'substantial' or 'critical' levels of need. In 2007/08, this had increased to 72 per cent (Commission for Social Care Inspection (CSCI), 2008), and by 2011/12 to 82 per cent (ADASS, 2011).

Between 2005 and 2010, the number of working-age adults (18- to 64-year-olds) using social care services rose by almost 12 per cent, but the number of older people being

supported fell by almost seven per cent (Humphries, 2011). This means most older people with 'moderate' or 'low' needs are not eligible for publicly funded support. The Commission for Social Care Inspection explored what happened to people who had failed to meet the council's eligibility criteria in 2008. It found that one third received help from their family, a further quarter paid for help and ten per cent were supported by a voluntary organisation. But a third of people, whose needs fell below the eligibility threshold, received no external help and had to manage on their own (CSCI, 2008).

50%

projected increase in social care costs between 2010/11 and 2025/26

This is consistent with research based on surveys of over-65s who are living at home, which has found that in recent years a significant number of older people who have difficulties with daily living activities such as dressing and bathing do not receive any support from either informal carers (family and friends) or publicly or privately funded support. In 2008, nine per cent of over-65s in the English Longitudinal Study of Ageing (ELSA) study reported difficulties with dressing and bathing, as measured by the Activities of Daily Living tool (ADL) (Banks and others, 2010). Of these, most received help from informal carers (51 per cent) and a further 20 per cent received state support, but almost a third (31.6 per cent) received no help at all (Vlachantoni and others, 2011).

Pressure on funding may also be impacting on quality of the services themselves, although the evidence is limited. Research funded by the Joseph Rowntree Foundation found that in most cases the fees paid by local authorities to care homes are too low to achieve the National Minimum Standards of Quality (Laing, 2008).

Box 1: Eligibility for social care

The Fair Access to Care Services (FACS) framework for assessment was implemented in England in 2003. Its aim was to establish a more consistent national framework for assessing eligibility for social care. Critically, it did not seek to achieve a position where individuals with similar needs receive similar services across the country, as it was acknowledged that councils would take account of their local resources. The eligibility framework is graded into four bands, which describe the seriousness of the risk to independence or other consequences if needs are not addressed. The four bands are as follows:

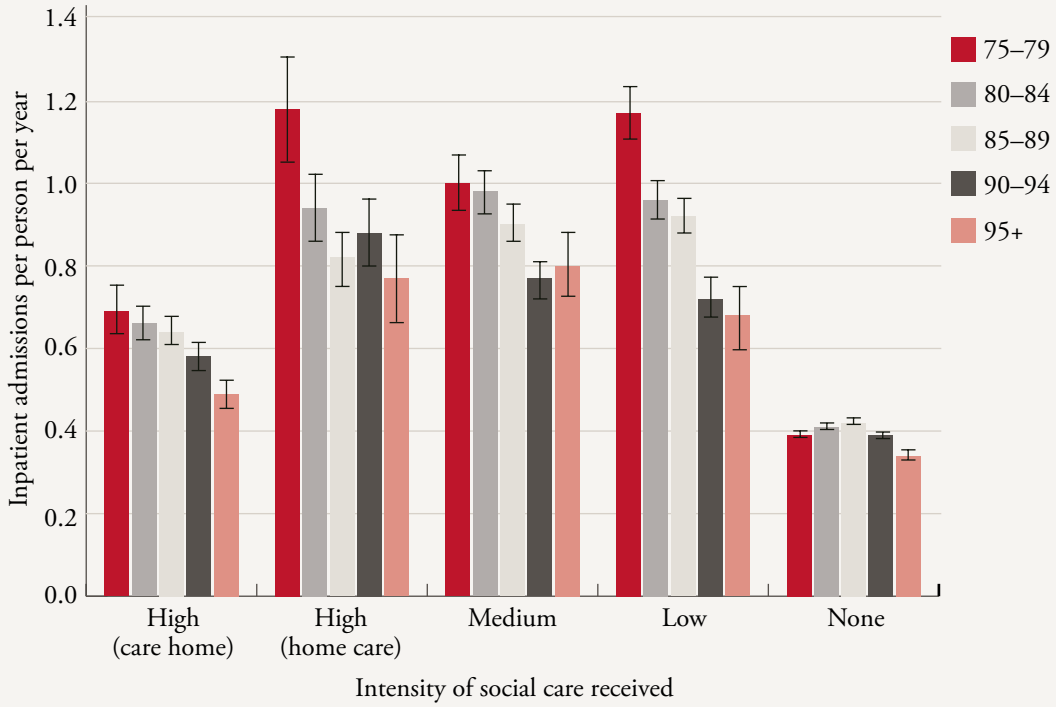
- **Critical** – when life or health is threatened and/or vital social or work roles cannot be maintained, and/or serious abuse/neglect will occur.
- **Substantial** – the majority of care routines cannot be carried out, many social or work roles cannot be maintained, or abuse/neglect may occur.
- **Moderate** – several care routines cannot be carried out, and/or several social or work roles cannot be maintained.
- **Low** – one or two care routines cannot be carried out, and/or one or two social or work roles cannot be maintained.

Department of Health, 2002; 2010c

Impact on NHS services

The threshold for access to adult social care is an important issue for social care users but may also have implications for the NHS. Research has found that in parts of the country where local authorities' spending on social care per head for the over-65s is lower, there were more delayed discharges from NHS hospitals and more emergency readmissions (Fernandez and Forder, 2008). Recent analysis by the Nuffield Trust of data on users of health and social care found that residents of residential care homes had fewer hospital admissions than their counterparts being cared for at home – see Figure 3 (Bardsley and others, 2012).

Figure 3: Number of inpatient admissions per person by age and type of social care received (with 95 per cent confidence intervals shown)



Source: Bardsley and others, 2012

It is not known whether higher admissions are associated with a lower quality of care at home than in residential care, but it serves to underline the connection between the intensity of social care and use of NHS services.

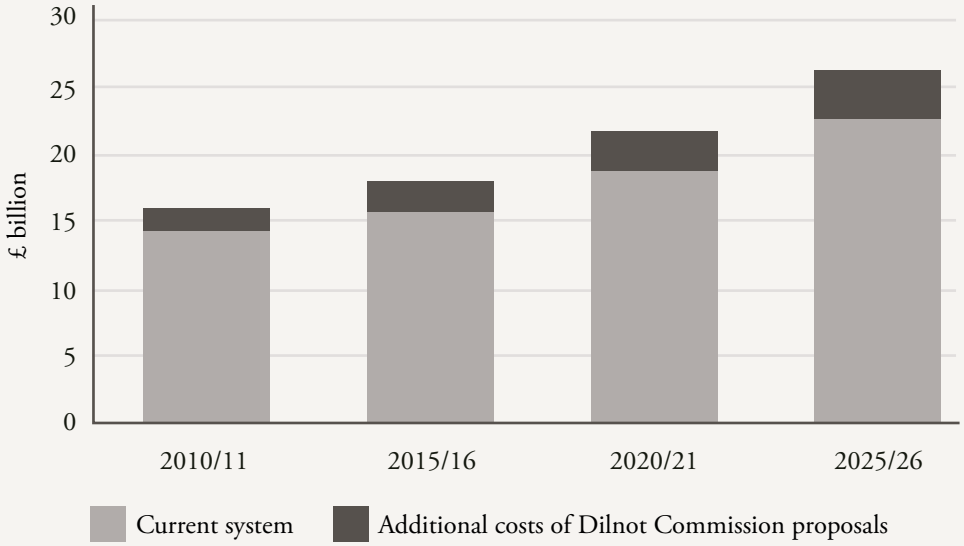
The future funding gap

The Dilnot Commission's calculations show how social care costs are projected to increase over the coming years as the number of older people, particularly those over 85, increases. Figure 4 shows the projected increase in costs with and without the Commission's reforms. Under the current system of financing, social care costs are projected to increase by over 50 per cent in real terms between 2010/11 and 2025/26. The Commission believes additional public funding for the means-tested system is urgently required, notwithstanding the resources made available through the 2010 Spending Review.

It is clear that the current model of publicly funded social care is under severe pressure. Unless new ways are found to resource adult social care, some of the most vulnerable

people in society, namely social care users on low incomes, will see their access to services even more constrained. This will have consequences, not only for individuals, carers and families, but also the NHS.

Figure 4: Social care public spending projections (at 2010/11 prices)



Source: Commission on Funding of Care and Support, 2011

The Dilnot Commission's recommendations

The Dilnot Commission was asked to make recommendations on "how to achieve an affordable and sustainable funding system or systems for care and support, for all adults in England, both in the home and other settings" (Department of Health, 2010b). The overarching aims of the Commission were to identify principles that could lead to a better balance between the responsibility of individual service users and the state, and to suggest ways of funding a care system based on those principles.

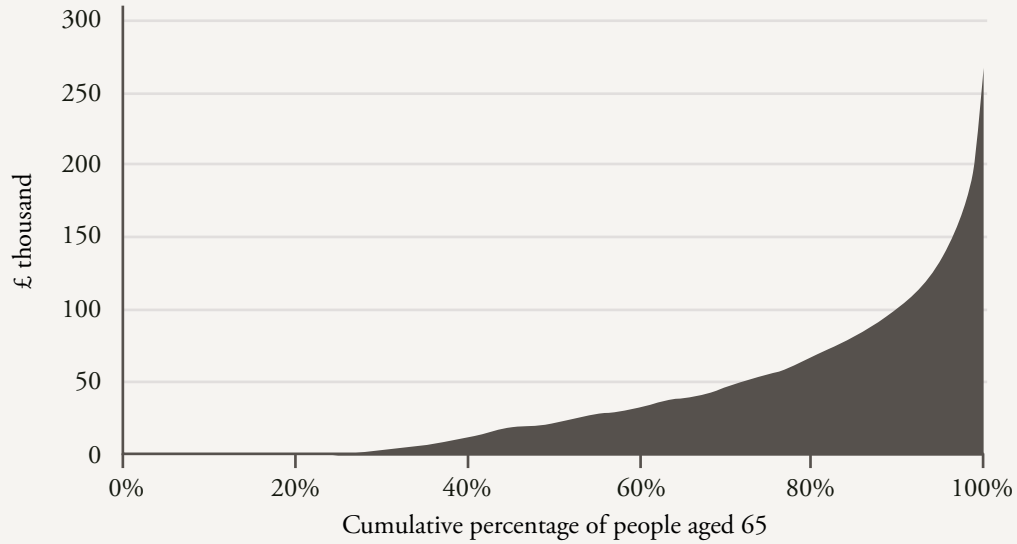
The principles included:

- the importance of protecting both those with low levels of income and wealth, and those who will experience high care costs over their lifetime, regardless of their means
- the responsibility of both the state and individuals to contribute towards the protection of people with low levels of income and wealth, and all those who require significant amount of social care
- that individuals who have higher levels of income and wealth should continue to pay for their care until the cost exceeds a specified level.

The Dilnot Commission's proposals address the inequities that come from the very high costs of care that a small proportion of the population face as a result of developing high needs. The majority of older people face lifetime care costs that are relatively modest, but a minority (ten per cent) face lifetime care costs of over £100,000 (Figure 5). The incidence of very high costs is not predictable for individuals.

For those who develop a care need in childhood or during their working life, the costs of care are higher and are even further skewed towards a small proportion of the population.

Figure 5: Expected future lifetime cost of care for people aged 65 in 2009/10 by percentile (2009/10 prices)



Source: Commission on Funding of Care and Support, 2011

In other areas of life where there is a small risk of an unpredictable event resulting in very high costs, insurance is used to pool the risk across a larger population. For social care, a private insurance market has not developed in the UK (though limited markets exist in other countries such as France and the United States). This is a reflection of a number of market failures including low consumer awareness, and actuarial uncertainty about the risk of social care need and the likely cost of care in the future. The Dilnot Commission proposed that the state funds the cost of care above a certain cap which in turn would increase the opportunity for private insurance products to develop for care costing less than the cap.

A second objective for the Dilnot Commission was to broaden the scope of state support through a more generous means-test threshold, to benefit those on lower incomes who might otherwise struggle to pay for their share of costs below the cap. The central financial recommendations of the Dilnot Commission are to:

- Place a cap on lifetime adult social care costs of around £35,000 for people whose care needs start over the age of 40. (The Commission says this cap could be in the range of £25,000 to £50,000.)
- Increase the provision of means-tested support for those with lower levels of income and wealth. Under the current system, no support is provided to people in residential care with assets (including housing assets) of more than £23,500, but this would be raised to £100,000 under the proposals.
- Standardise the amount that individuals should contribute to cover their general living costs in residential care to between £7,000 and £10,000 a year.

- Make adult social care free to those who enter adulthood with a care need, on the grounds that by virtue of age and circumstances they could not reasonably have been expected to make provision for possible social care needs, and that their opportunity to build up their stock of personal assets will have been very limited.
- Retain the current cash disability benefits for adults – attendance allowance and disability living allowance – but better align these benefits with the social care system following reform, and rebrand attendance allowance to clarify its purpose.

There are a range of linked recommendations that relate more to the delivery of social care. These include changes to the assessment process to make it more transparent and standardised across the country, better information for users and families, and greater efforts to integrate health and social care services (Commission on Funding of Care and Support, 2011).

Analysis

The Dilnot Commission makes it clear that more should be spent on social care and the extra funding should come both from individuals' private wealth or income, and from the state (though this is ultimately from taxpayers). Although the Royal Commission (Department of Health, 1999) recommended that the state fund free personal care, a consensus has begun to emerge since then that it is reasonable to share responsibility for the costs of catastrophic care needs between the individual and the state. Proposals such as Sir Derek Wanless' report on a 'partnership' funding model (Wanless and others, 2006) also recognise that sustainable funding for social care will need to be based on both contributions from individuals and public funds.

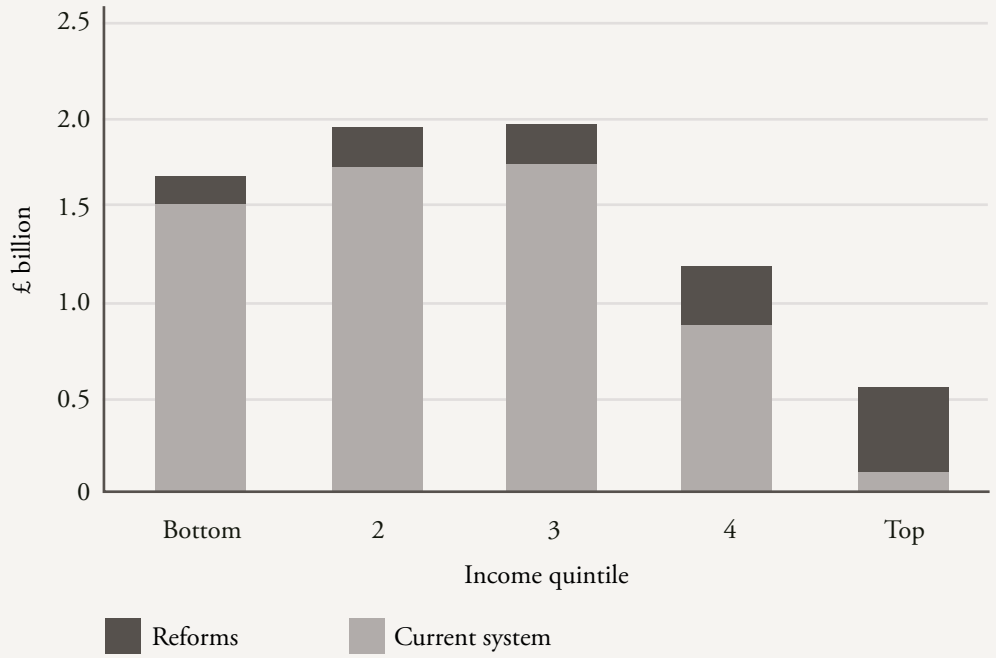
£1.7 bn

additional annual cost of implementing the Dilnot Commission's recommendations

Two aspects of the recommendations are of particular note. First, although the Dilnot Commission attempts to strike a balance between people with differing levels of income and wealth, the cap in particular delivers greater benefit to the better-off, as public funds are used to protect more of their wealth than under current arrangements (see Figure 6). This is an important point of context for any discussions on how public expenditure might be raised or reallocated to fund this aspect of the Commission's recommendations. It poses an important question about fairness and may have consequences for generating public support if, for example, welfare payments to older people as a whole are reduced in order to generate additional public expenditure, the bulk of which will be spent on wealthier older people. It will be important to conduct a comprehensive impact assessment to model the effects of the various options set out in this paper.

A second point relates to eligibility for state support. The Commission's recommendations are based on standardising the assessment threshold at the current 'substantial' FACS category (see Box 1 on page 8). It will be important that this threshold for eligibility should not be too high. Increasing the scope of means-tested support would be undermined if only a very small percentage of those needing social care are able to qualify. As mentioned above, local authorities are restricting access to care due to rising demand and diminishing resources. It will be important to clarify the thresholds for support as well as the methods for assessing them.

Figure 6: Public expenditure on social care for older people in 2010/11 – the current system and additional expenditure from proposed reform, by quintiles of older people's income



Source: Commission on Funding of Care and Support, 2011

The source of funding

The recommendations from the Dilnot Commission assume that if the state pays for costs of care beyond a lifetime threshold, this will encourage new forms of insurance and financial products to develop that allow individuals to use their own savings or housing wealth. It is important that work is undertaken with the public and with providers of financial services to develop these. However, the remainder of this paper is concerned with finding the resources for the public side of the funding equation: raising new sources of public funding for social care.

> One potential source of additional public sector funding for social care is to shift some money from welfare payments made to older people into social care

The Dilnot Commission's recommendations would add £1.7 billion a year to public spending on adult social care (based on 2010/11 prices and current population projections). This represents a 12 per cent increase on the current adult social care budget of £14.6 billion (of which just over half is for older people). Over the longer term, if the Commission's recommendations were adopted, public spending on social care would rise by 85 per cent rather than the 50 per cent increase projected without policy change by 2025/26. The difference is substantial – by 2025/26 the Dilnot Commission's proposals would add £3.6 billion to public spending on social care.

In the next section, we consider three options which may be considered on their own or in combination:

- reducing the costs of implementing the Dilnot proposals
- redistributing funds from health to social care
- redistributing older people's income or wealth through reform of current welfare payments and/or taxation.

Opting for a higher cap

There is a strong case for the Dilnot Commission's central recommendation to cap individuals' lifetime costs of social care. But the Government should consider whether this cap should be set at £50,000 rather than the £35,000 proposed in the final report. Reducing the cost could help protect means-tested provision and facilitate a recalculation of the eligibility criteria.

Raising the cap to £50,000 (the upper limit the Dilnot Commission recommends) would reduce the cost of this element of the Dilnot Commission's proposals by £600 million a year. A further £300 million could be saved if the contribution towards living costs were set at £10,000 rather than £7,000 a year. Table 1 shows that the total costs of the Dilnot Commission proposals vary according to the level of the cap and living costs threshold.

Table 1: The additional costs of care (at 2010/11 prices) for varying levels of the cap on lifetime care costs for older people and their contribution to general living costs

	Lifetime care costs cap	
	£35,000	**£50,000**
Living costs a year **£7,000**	£1.7 billion	£1.1 billion
£10,000	£1.3 billion	£0.8 billion

Source: Commission on Funding of Care and Support, 2011

The case for a higher cap is that it reduces the cost pressures in a time of financial challenge for the public sector. Setting a cap at £50,000 is not without risks. Modelling should be conducted to understand who will benefit from state support once the cap has been reached. There is also a risk to the development of new private financing products at levels which individuals consider affordable and value for money.

Acknowledging that more information is needed in order to make a full assessment of where the cap should lie, at present we think a cap of £50,000 should still deliver most of the Dilnot Commission's objectives and most importantly the 'savings' could be used to reduce the threshold for publicly funded adult social care, ensuring that more people receive the care that they need, which would bring potential benefits for themselves, their carers and other services such as the NHS.

Reforming the funding system for domiciliary care

At present, the rules governing whether an individual receives state funding for social care differ according to whether the person receives care at home or in a residential care setting. Eligibility for state support of domiciliary care depends largely on the income of the individual, whereas eligibility for residential care also considers housing assets. The Dilnot Commission acknowledges the case for greater consistency in the treatment

of housing wealth. The Commission argues that in future, two changes to the funding system for domiciliary care should be considered: bringing housing assets within the scope of the means test and introducing a taper so that public funding is withdrawn at a rate of 65 per cent instead of 100 per cent, for income above the current means-tested threshold (approximately £170 a week) (Commission on Funding of Care and Support, 2011). Reducing the taper would add around £200 million a year to the cost of publicly funded social care (at 2010 prices). On the other hand, including housing assets in the domiciliary care means test would result in a saving to the public purse of around £1.2 billion at 2010 prices. Together these changes would result in a net saving of £1 billion (Wittenberg and others, 2011).

> A cap on lifetime costs has the effect of protecting individuals' accumulated assets

Such a change may appear very attractive to policy-makers looking to reduce funding pressures on social care. The Dilnot Commission recognises its logic – and theoretical merits – but cautions that there are practical issues to be addressed: housing assets are hard to realise and arrangements would need to be in place to help people access their wealth. Local authorities could extend their deferred payment scheme, which allows someone who goes into care to keep their property and get help from the local authority with paying social care fees. The local authority subsequently recovers the fees from the proceeds when the property is sold. The Commission also recognises that this might be unpopular with the public. It would be important that people did not avoid using care as a way of avoiding the housing-based means test, thereby putting pressure on health services if informal care or voluntary services were unable to fill the gap (Commission on Funding of Care and Support, 2011).

Reprioritising public service spending

In the 2010 Spending Review, the Government identified savings of £36 billion in public services by 2014/15. Funding the Dilnot Commission proposals within current fiscal plans would require a further £2 billion-plus to be found by the end of the spending review period. With the exception of health and overseas aid, the budgets of other government departments are being reduced by 19 per cent in real terms between April 2011 and March 2015 (Crawford, 2010). Against this background, an additional £2 billion looks very demanding.

The health budget was given a relatively generous treatment in the Spending Review, with funding broadly constant in real terms. Moreover, as work by the Nuffield Trust shows, social and health care services are closely connected (Bardsley and others, 2012). One option for reprioritised spending on public services would be to shift resources from health into social care. Funding for health care has grown at twice the rate of social care funding over recent years, but it is not clear that this differential rate of growth has delivered the most cost-effective mix of health and social care, particularly for very elderly people with complex health and care needs who receive support from both the NHS and social care providers. But the evidence is not clear-cut: attempts to invest in enhanced, preventative social services at the patient or community level have often not delivered the anticipated level of savings (Steventon and others, 2011).

As explained above, the 2010 settlement for the health service made provision for £2 billion of the health budget to be spent on social care over the next four years. Shifting a further £1.7 to £2 billion would result in a real-terms reduction in the health budget over the spending review period. This would make the existing NHS productivity challenge of four to five per cent a year even harder to achieve. An additional £2 billion would increase the productivity requirement to at least six per cent, a perhaps unrealistic goal.

However, it is noteworthy that despite the pressures on funding, the NHS is on track to deliver a surplus in 2011/12, as it has done for a number of years: the expected PCT surplus is currently £1.5 billion (Flory, 2012). This represents over 80 per cent of the cost of implementing the Dilnot Commission recommendations at current prices. The 2010 Spending Review established the principle that health funding could be earmarked to support social care with projects that would meet individuals' care needs and to focus on services that could reduce avoidable use of the NHS. The Department of Health should consider using part of the PCT surplus for further transfers to social care, to protect and extend eligibility and support preventative work. Transfers should focus on social care programmes that offer both potential benefit to service users and efficiency gains for health and social care. However, it is very important that alongside any short-term action of this kind, there is new impetus for analytical work that increases our understanding of the potential benefits and risks that shifting resources between health and social care might bring. The Department of Health should consider a review of the optimal balance between health and social care funding before the next spending review.

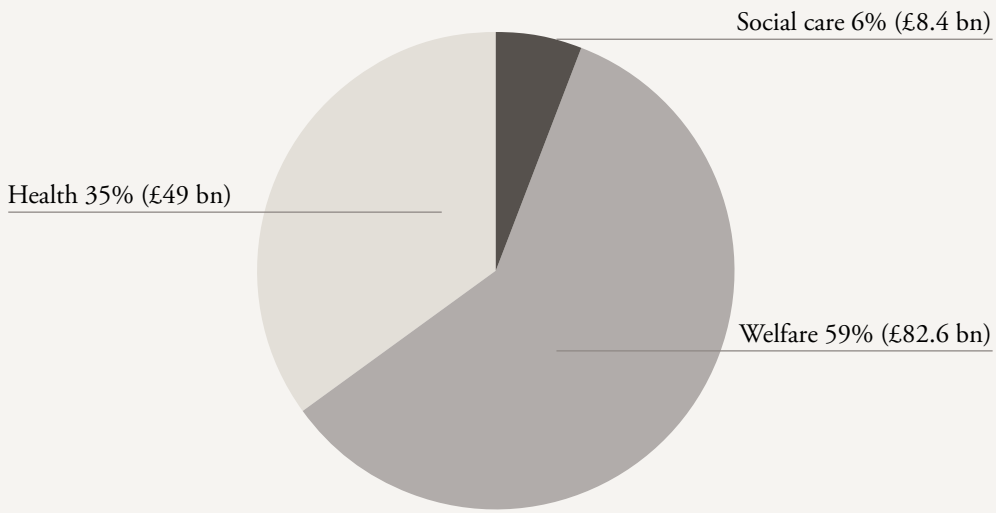
Redistribution of welfare payments

Public spending on older people includes spending on services such as the NHS and social care but also welfare payments to individuals. Welfare payments such as the state pension are the largest element of state support for the over-65 age group, at 59 per cent of the £140 billion a year (see Figure 7).

One potential source of additional public sector funding for social care is to shift some money from welfare payments made to older people into social care. The Commission considered this in relation to social care and the key disability benefits – Attendance Allowance and Disability Living Allowance. The Dilnot Commission concluded that universal disability benefits should remain – although it recommended clarifying the role of Attendance Allowance and more closely aligning the assessment systems. Further restricting disability benefits in order to fund social care is counterproductive, as it shifts funds away from people with established care needs.

The Dilnot Commission's proposals are based on the principle of sharing and pooling risk across a wider group. All older people are at risk of a significant care need and the beneficiaries of a state-funded cap include all those with income and wealth above the cap in current and future generations. Therefore, those with limited assets and income, who have little scope of acquiring them, do not stand to benefit from the cap on lifetime care costs and it would not be consistent with the insurance principle to ask them to contribute. This suggests that the Government should look more widely across the full range of welfare payments to older people.

Figure 7: Public spending on older people



Source: Commission on Funding of Care and Support, 2011

One potential source of funding, therefore, could come from restricting some of the universal benefit payments to older people with higher incomes and wealth. This could include, for example, the winter fuel payment, free TV licenses and travel concessions (the free bus pass). Arguments in favour of such a proposal would need to balance the financial benefits (up to £1.4 billion a year) against the costs in terms of fairness and the impact on social solidarity (tying all people into welfare), which can be hard to quantify. It is important to ensure that any restriction on payments does not disproportionately impact on those with incomes just above the state pension or in receipt of pensions credit.

Taxation of older people

The Dilnot Commission argued that if the Government concludes that additional revenue needed to be raised, "it would make sense for this to be paid at least in part by those who are benefiting directly from the reforms. In particular, it would seem sensible for at least a part of the burden to fall on those over state pension age."

Focusing revenue-raising on older people rather than the general population may seem counter-intuitive given that the incomes of older people are on average below those of the working-age population. Equivalised[1] average disposable household income for those below retirement age in 2009/10 was around £30,000 whereas for the retired, the equivalent amount is a third lower at almost £20,000 (Barnard and others, 2011). But the effective rate of taxation for older people is lower, on average, than for working-age people of a similar income. This is in part the result of national insurance being payable only below retirement age.

1. 'Equivalisation' adjusts a household's income for size and composition, recognising that households of different sizes will need different income levels to achieve the same living standard.

Table 2 shows the relationship between gross and disposable income for those above and below retirement age for a section of better-off older people.

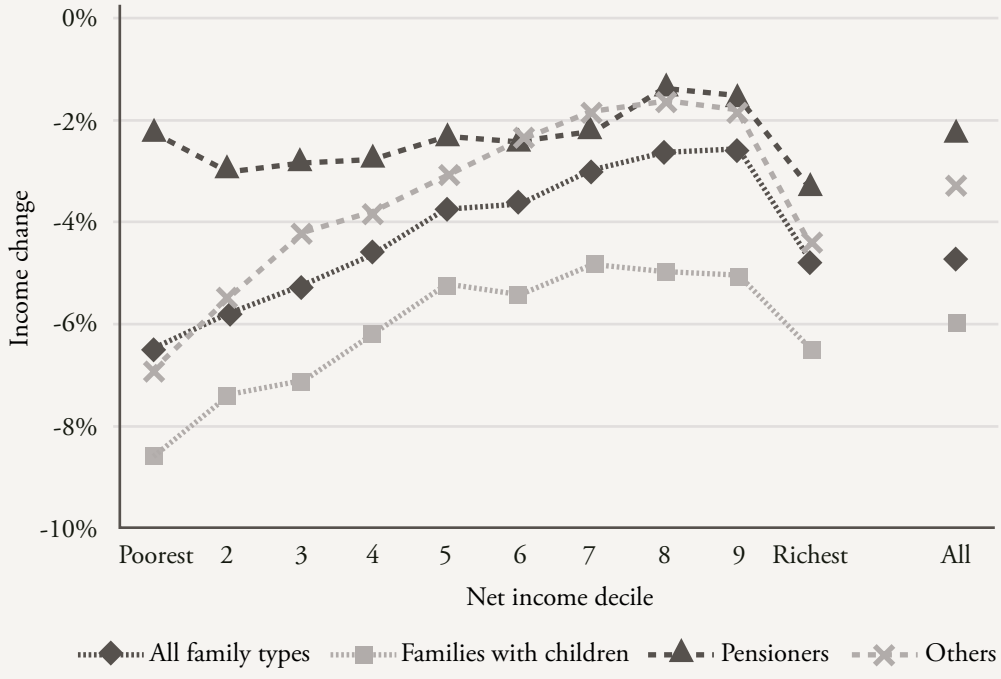
Table 2: Comparison of tax burden for incomes at the eighth decile for retired households (figures rounded)

	Non-retired	Retired
Gross income	**£23,000**	**£23,000**
Direct tax	£3,000	£2,750
Disposable income	£20,000	£20,250
Indirect tax	£4,350	£3,500
Post-tax income	**£15,600**	**£16,700**

Note: The eighth decile is the income point at which 70 per cent of retired households have less than this income, and 30 per cent have more.
Source: Barnard and others, 2011

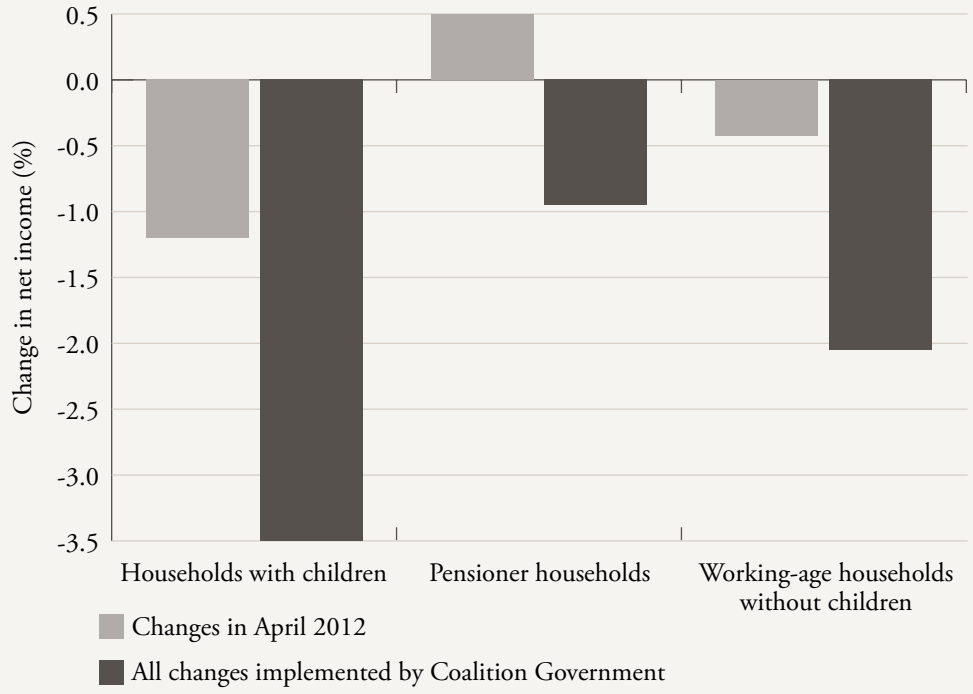
Pensioners' average income has also grown faster than earnings over the last eleven years: net income (after housing costs) for pensioner households grew by 47 per cent between 1998/99 and 2009/10, more than three times the increase in average earnings, which rose by 14 per cent in real terms over the same period (Department for Work and Pensions, 2011). To some extent, pensioners' income has also been protected from the current reforms to the tax and benefit system, which are primarily designed to reduce public spending. Research shows that the reforms implemented from 2008/09 are having greatest impact on poorer households and on families with children (except for those families on the very highest incomes). Figure 8 shows that across almost all the income distribution, pensioners' net income will see the smallest percentage change as a result of the Government's reforms (Jenkins and others, 2011).

Figure 8: Distributional impact of modelled tax and benefit reforms implemented between January 2011 and April 2014 in the UK, by income and family type



Source: Jenkins and others, 2011

Figure 9: Impact of changes taking effect by April 2012



Note: ignores measures affecting mainly the very rich
Source: Joyce, 2012

In the 2012 Budget, the Government announced further changes to the tax and benefit system and, in particular, proposals to more closely align the tax allowances for older people and working-age adults on lower incomes (HM Treasury, 2012). Analysis by the Institute for Fiscal Studies (IFS), shown in Figure 9, illustrates that after these changes have taken effect, the impact of reforms to the tax and benefit system will have been greater for working-age adults – with and without children – than for those above retirement age (Joyce, 2012).

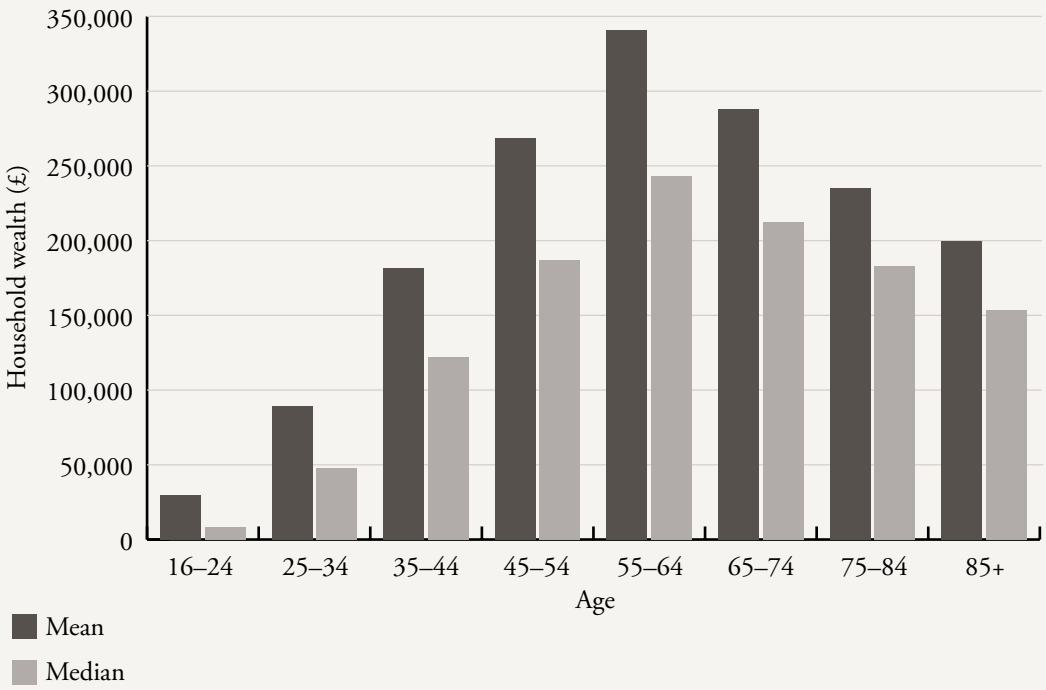
£3 bn

Estimated annual yield from a five per cent tax on estates above £25,000

In addition to income, there are also significant differences in the levels of household wealth between different groups in society and by age and age cohort. Home ownership is one of the key factors in levels of wealth and has been rising since the 1970s. By 2009, 67 per cent of households in Great Britain owned their home, with or without a mortgage (Department for Communities and Local Government, 2012). Among the older age groups, 73 per cent of those over 65 owned their home in 2009 (ONS, 2011b). Ownership rates are highest for 65- to 74-year-olds and fall to 65 per cent of those aged 85 and over – almost certainly reflecting the effects of the upward trend in home ownership. Figure 10 shows the distribution of wealth by age group, with the highest levels of wealth among those aged from 55 to 74.

If revenue-raising were to focus on older people, there is a case for any additional contribution to the cost of protecting individuals from the risk of very high care costs to be targeted at the better-off elderly. This is the group that would receive the greatest benefit from the Dilnot Commission proposals, as a cap on lifetime costs has the effect of protecting individuals' accumulated assets (see Figure 6 on page 13).

Figure 10: Household wealth excluding pension wealth (£)



Source: Daffin, 2009

Taxation options

Taxation is a complex area because any changes to taxation rates interact with incentives to save, particularly for pensions, and with incentives to work. Recent work undertaken by the IFS for the Nuffield Foundation has explored the revenue-raising potential and possible advantages and disadvantages of a range of options for funding the Dilnot Commission proposals (Browne and Johnson, 2011). It explored a series of possible tax measures including:

- imposing employee national insurance contributions on pensioners' earnings
- reducing the generosity of the tax treatment for lump sums (currently individuals can take 25 per cent of their pension pot as a tax-free lump sum, up to a limit of £437,500)
- restricting tax relief on pension contributions to the basic rate of income tax.

Table 3 summarises the IFS analysis of the options. This is not a comprehensive list of possible measures but provides some illustration of the sums of money involved, and highlights what the researchers saw as the potential advantages and disadvantages of each.

Table 3: Comparison of some revenue-raising options focused on older people's incomes

	Annual revenue potentially available for social care	Advantages	Disadvantages
Restricting winter fuel payments and free TV licences to those on Pension Credit	£1.4 billion	The poorest pensioners who claim Pension Credit are protected.	Some research evidence that winter fuel allowance increases pensioner spending on fuel, which addresses fuel poverty problems. Unfair on those with modest means: those just beyond the threshold to qualify for Pension Credit lose most.
Imposing Employee NICs on pensioner earnings	£400 million	Only the richest pensioners are significantly affected, as only the wealthiest tend to work beyond state pension age.	Weakens work incentives for this age group.
Reducing the generosity of the tax-free lump sum	£2.5 billion (if abolished completely)	Corrects a perceived anomaly in the current tax system.	Reducing it too fast would reduce the incentive to save. Unlikely to yield much money as most people will have a modest lump sum; would need to be phased in carefully.
Restricting tax relief on pension contributions to the basic rate	£7 billion	Removes a perceived unfairness in the tax system; affects the better-off (beneficiaries of Dilnot lifetime cap).	Complex to administer for defined benefit schemes. Only future pensioners are affected. Weakens incentive to save.
Up-rating pensions in line with earnings	£1.5 billion	Minimal administrative costs or complexity.	Poorer pensioners protected by pension credit but lose more on average than wealthier pensioners. Slightly weakens the incentive to save for retirement.
Levying capital gains tax at death	£670 million	Targets wealthier people, as tax applies only to gains over £10,600, and gains from banks, ISAs and main residence are not included. Corrects distortionary system: absence of capital gains at death encourages people to hold onto assets rather than sell them to reinvest elsewhere.	Could undermine incentives to save.

Source: Browne and Johnson, 2011

The IFS research (Brown and Johnson, 2011) focused mainly on options to tax income rather than wealth. Taxes on wealth include capital gains tax and inheritance tax (IHT). The research estimated that £670 million might be raised by levying capital gains tax at death. The authors argue that the current regime is highly distorting – as it encourages people to hold onto assets until death – but recognise that such a tax might have a negative impact on the incentive to save. The main tax on assets at death in the UK is IHT. The proportion of estates paying inheritance tax has declined over recent years with the introduction of the transferable nil rate band in 2007, which allowed unused IHT allowances to be transferred to surviving spouses and civil partners. In 2010/11 the Government received £2.7 billion in IHT receipts, compared with £3.8 billion in 2007/08.

The previous government proposed a new tax on wealth at death to fund free personal care. However, there were concerns that such a system would be difficult to implement as it would require a relatively large increase in the tax and may result in wealth being shifted between family members to avoid the tax, reducing the revenue raised as a result. There were many criticisms of the specific tax proposal advanced by the previous government. But some are calling for the revival of a wealth tax model to fund social care reform. The Strategic Society Centre has done further analysis and suggests that a new inheritance tax to fund the costs of implementing the Dilnot Commission's recommendations would be practically and politically feasible. They calculate that a five per cent tax on all estates above £25,000 would yield around £3 billion a year (Lloyd, 2011b). Others (for example Dolphin, 2010) argue that there are better ways to tax wealth and assets, and that inheritance tax should be replaced altogether.

A reformed social care system would provide direct benefits to older people, by securing fairer access to publicly funded care designed to meet a wider range of social care needs. Capping the lifetime costs of social care would also give better-off older people the scope to determine what should happen to more of their assets either before or after their death. However, there has been some debate about whether the older generation would benefit from this change. If not, this might undermine the case for asking older people to pay towards a reformed system.

These debates are beyond the scope of this paper, but we believe it would be reasonable to consider reform of taxes on wealth as a source of funding for social care. The Government should undertake further work to explore options that could command public support and would have limited scope for tax avoidance. The objective of reforming the tax system in order to fund a cap on lifetime social care costs would be to levy a low rate of tax across as many of those with assets above the means-tested threshold as possible.

Deciding between the funding options

The Nuffield Trust does not undertake research on tax and welfare payments. As a result we are not in a position to offer views on the detail of tax or welfare payment options to fund the Dilnot Commission proposals. In view of the current economic and fiscal climate we believe that it might be challenging to argue for higher taxes unless the Government was confident that structural inefficiencies in the balance of public spending (including health and welfare payments) had been addressed first. In any event, the Government should establish criteria to assess the tax and welfare options. These could include that:

- New revenue sources to meet the additional publicly funded costs of social care should be progressive and distributionally neutral (in other words, those who benefit most from the additional spending should pay most through any additional taxation or lose most through reduced welfare payments).
- Additional revenue-raising measures should be administratively simple and have low administrative costs. This points to using an existing tax rather than creating new taxes.
- The measures used to raise additional revenue should seek to minimise perverse incentives or other distortions (for example, on the incentive to save for old age or extend people's working lives).

Conclusions

The current system of funding social care is under severe strain and is widely perceived to be unfair. The Dilnot Commission has done a commendable job of crafting principles that command considerable support and proposals that are underpinned by sound analysis. The Government's planned Care and Support White Paper needs to provide a substantive response to the Dilnot Commission's proposals. But it is imperative that it also addresses the underlying funding gap which has emerged, and which will worsen over the coming decade if no action is taken. Failure to address social care funding will put vulnerable older people at risk and will increase pressure on the NHS.

If the White Paper is to achieve the two central objectives of the Dilnot recommendations – to support adults with low incomes who are most dependent on an effective publicly financed system and to support all people who face very high care costs – it needs to set out specific proposals to increase the public funding for adult social care. In the first instance, the Government should consider transferring some of the PCT surplus being accumulated in 2011/12 to social care, in order to avoid further restrictions on eligibility which will impact on vulnerable older people and potentially the efficiency of the NHS.

The Government should also re-examine the allocation of £140 billion of public spending on older people to consider whether shifting some additional funding from health and welfare payments would produce a more efficient and effective package of help to older people. If all of the costs cannot be met through reprioritisation there is a case for increased, targeted taxes. Any such tax increases should be levied in a way that is progressive and has a neutral impact on the distribution of income and wealth across ages and income groups.

We do not underestimate the challenge of this, not least in changing public attitudes. As the Dilnot Commission pointed out, many people are unaware that social care is not free. Gaining public support for raising taxes or redistributing some of the welfare benefits currently received by better-off older people will require a prolonged campaign to educate the public about the risks they might otherwise face. If people are asked to contribute more of their own wealth, via taxation or private contributions, it will also be crucial that publicly funded services are seen to be of good quality. It is therefore vital that the Government presses ahead with reforms to deliver a social care system that is both high-quality and financially sustainable.

References

Age UK (2012) *Care in Crisis 2012*. Available at: www.ageuk.org.uk/Documents/EN-GB/Campaigns/care_in_crisis_2012_report.pdf?dtrk=true

Association of Directors of Adult Social Services (2011) *ADASS Budget Survey 2011*.

Audit Commission (2011) *Improving Value for Money in Adult Social Care*.

Bardsley M, Georghiou T, Chassin L, Lewis G, Steventon A and Dixon J (2012) 'Overlap of hospital use and social care in older people in England', *Journal of Health Services Research Policy*. DOI: jhsrp.2011.010171.

Banks J, Lessof C, Nazroo J, Rogers N, Stafford M and Steptoe A (2010) *Financial Circumstances, Health and Well-being of the Older Population in England. The 2008 English Longitudinal Study Of Ageing (Wave 4)*. Institute for Fiscal Studies.

Barnard A, Howell S and Smith R (2011) *The Effects of Taxes and Benefits on Household Income, 2009/10. Further analysis and methodology.* ONS.

Browne J and Johnson P (2011) *Options for Raising Revenue to Pay for Long-term Care*. London: Institute for Fiscal Studies. Available at: www.ifs.org.uk/docs/nuffield_281111.pdf

Commission for Social Care Inspection (2008) *Cutting the Cake Fairly: CSCI review of eligibility for social care*. Commission for Social Care Inspection.

Commission on Funding of Care and Support (2011) *Fairer Care Funding – The report of the Commission on Funding of Care and Support*. Available at: www.dilnotcommission.dh.gov.uk/files/2011/07/Fairer-Care-Funding-Report.pdf

Crawford R (2010) *Where Did the Axe Fall?* Institute for Fiscal Studies. Available at: www.ifs.org.uk/publications/5311

Daffin C (2009) *Wealth in Great Britain: Main results from the Wealth and Assets Survey 2006/08*. ONS.

Department for Communities and Local Government (2012) *Table 102. Live tables on dwelling stock in Great Britain*. Available at: www.communities.gov.uk/documents/housing/xls/table-102.xls

Department for Work and Pensions (2011) *The Pensioners' Incomes Series 2009/10*.

Department of Health (1999) *With Respect to Old Age: Long Term Care – Rights and Responsibilities. A report by The Royal Commission on Long Term Care*. Cm 4192-I. The Stationery Office.

Department of Health (2002) *Fair Access to Care Services – Guidance on eligibility criteria for adult social care*.

Department of Health (2010a) *Building a National Care Service*. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_114923.pdf

Department of Health (2010b) *Dilnot Commission Terms of Reference*. Available at: www.dilnotcommission.dh.gov.uk/files/2010/11/Tor-final.pdf

Department of Health (2010c) *Prioritising Need in the Context of Putting People First: A whole system approach to eligibility for social care. Guidance on Eligibility Criteria for Adult Social Care, England 2010*.

Dolphin T (2010) *Death and Taxes: Why Inheritance Tax should be replaced with a Capital Receipts Tax*. Institute of Public Policy Research.

Equality and Human Rights Commission (2011) *Close to Home: An inquiry into older people and human rights in home care*. Available at: www.equalityhumanrights.com/uploaded_files/homecareFI/home_care_report.pdf

Fernandez, J-L and Forder J (2008) 'Consequences of local variations in social care on the performance of the acute health care sector', *Applied Economics* 40(12), 1503–1518.

Flory D (2012) *The Quarter: An update from David Flory, NHS Deputy Chief Executive*, Quarter 3, 2011/12. Department of Health. Available at: www.dh.gov.uk/health/files/2012/03/Quarter3_27-March-2011-12.pdf

HM Treasury (2011) *Public Expenditure Statistical Analysis July 2011*. Cm8104. The Stationery Office.

HM Treasury (2012) *Budget 2012*. HC1853. The Stationery Office.

House of Commons Health Committee (2012) *Fourteenth Report of Session 2010–12, Social Care*, HC 1583-II, Department of Health, Ev 130.

Humphries R (2011) *Social Care Funding and the NHS: An impending crisis?* The King's Fund.

Humphries R and Curry N (2011) *Integrating Health and Social Care: Where next?* The King's Fund.

Jenkins SP, Brandolini A, Micklewright J and Nolan B (2011) 'The Great Recession and the Distribution of Household Income', version 22 July 2011. Presented at: Incomes Across the Great Recession, XIII European Conference of the Fondazione Rodolfo Debenedetti, Palermo, 10 September.

Joyce R (2012) *Tax and Benefit Changes, Excluding Those Affecting Mainly the Rich*. Institute for Fiscal Studies. Available at: www.ifs.org.uk/budgets/budget2012/budget2012robjoyce.pdf

Knapp M, Prince M, Albanese E, Banerjee S, Dhanasiri S, Fernandez J-L, Ferri C, McCrone P, Snell T and Stewart R (2007) *Dementia UK: A report to the Alzheimer's Society on the prevalence and economic cost of dementia in the UK*. The Alzheimer's Society.

Laing W (2008) *Calculating the Costs of Efficient Care Homes*. Joseph Rowntree Foundation. Available at: www.jrf.org.uk/sites/files/jrf/2260.pdf

Lansley A (2011) Statement to House of Commons, *Hansard*, 4 July.

Law Commission (2011) *Adult Social Care* (Law Com No. 326); HC 941. London: The Stationery Office.

Lloyd J (2011a) *Inheritance Tax: Could it be used to fund long-term care?* The Strategic Society Centre.

Lloyd J (2011b) *The First Step? A response to the Commission on Funding of Care and Support*. The Strategic Society Centre.

NHS Information Centre (2011) *Personal Social Services Expenditure and Unit Costs: England, 2009–10*.

NHS Information Centre (2012) *Personal Social Care Expenditure and Unit Costs: England, 2010–11*.

Nuffield Trust (2012) *Social Care and Hospital Use at the End of Life*. Available at: www.nuffieldtrust.org.uk/our-work/projects/social-care-and-hospital-use-end-life . Accessed 5 April.

ONS (2011a) *2010-based National Population Projections*.

ONS (2011b) *Older People's Day 2011*. Statistical Bulletin September 2011.

Phelps M, Kamarudeen S, Mills K and Wild R (2010) *Total Public Service Output, Inputs and Productivity*. ONS.

Steventon A, Bardsley M, Billings J, Georghiou T and Lewis G (2011) *An Evaluation of the Impact of Community-based Interventions on Hospital Use: A case study of eight Partnership for Older People Projects* (POPP). Nuffield Trust.

Vlachantoni A, Shaw R, Willis R, Evandrou M, Falkingham J and Luff R (2011) *Measuring Unmet Need for Social Care Amongst Older People*. Population Trends nr 145, Autumn 2011. ONS.

Wanless D, Forder J, Fernandez J-L, Poole T, Beesley L, Henwood M and Moscone F (2006) *Wanless Social Care Review: Securing good care for older people*. The King's Fund. Available at: www.kingsfund.org.uk/publications/securing_good.html

Wittenberg R, Hu B, Hancock R, Morciano M, Comas-Herrera A, Malley J and King D (2011) *Projections of Demand for and Costs of Social Care for Older People in England, 2010 to 2030, under Current and Alternative Funding Systems*. PSSRU Discussion paper 2811/2. Personal Social Services Research Unit.

Further reading

Ahgren B and Axelsson R (2005) 'Evaluating integrated health care: a model for measurement', *International of Integrated Care* 5(31).

Alakeson V (forthcoming) *Integrated Care and Efficiency* (working title). Nuffield Trust.

Armitage GD, Suter E, Oelke ND and Adair C (2009) 'Health systems integration: state of the evidence', *International Journal of Integrated Care* 9(17), 1–11.

Association of Directors of Social Services and Local Government Association (2011) *How to Make the Best Use of Reducing Resources – A whole systems approach*. ADASS. Available at: www.adass.org.uk/index.php?option=com_content&view=article&id=671:resources-reduction&catid=144:resources-reduction&Itemid=440

Curry N and Ham C (2010) *Clinical and Service Integration: The route to improved outcomes*. The King's Fund.

Department of Health (2009) *Personal Health Budgets: First steps*. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117262.pdf

Department of Health (2010) *Homecare Re-ablement Prospective Longitudinal Study – Final Report*. Available at: www.csed.dh.gov.uk/asset.cfm?aid=6672

Department of Health (2011) *Briefing Notes on Amendments to the Health and Social Care Bill*, 24 June.

HM Revenue and Customs (2004) *Table 12.9: Destination of Assets on Death October 2004*. Available at: www.hmrc.gov.uk/stats/inheritance_tax/table12_9.pdf

Johnson B (2011) 'Deriving trends in life expectancy by the National Statistics Socio-economic Classification using the ONS Longitudinal Study', *Health Statistics Quarterly* 49, Spring. ONS.

Ling T, Bardsley M, Adams J, Lewis R and Roland M (2010) 'Evaluation of UK integrated care pilots: research protocol', *International Journal of Integrated Care*.

New B (1997) 'The rationing debate: defining a package of healthcare services the NHS is responsible for: the case for', *BMJ* 314, 498.

Shaw S and Levenson R (2011) *Towards Integrated Care in Trafford*. Nuffield Trust. Available at: www.nuffieldtrust.org.uk/sites/files/nuffield/publication/towards_integrated_care_in_trafford_report_nov11.pdf

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