

Approaches to social care funding

Social care funding options

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The King's Fund

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Abstract

This paper considers the following approaches to funding social care for older people in England.

- Improving the current system.
- The Conservative Party's proposals at the time of the 2017 general election (a revised means test and a cap on care costs).
- A single budget for health and social care.
- Free personal care.
- A hypothecated tax for social care.

These models were chosen to reflect the solutions most commonly raised in the debate around social care funding, and are not a comprehensive list of possible models.

We undertook a review of relevant literature and engaged with two stakeholder groups to develop a framework for exploring these options, and to identify the key strengths and weakness of each. Our objective is not to put forward a single recommendation, but to set out the implications of each of the models.

We conclude that:

- There is scope for making small improvements within the current system, and this approach would recognise the great difficulty successive governments have faced in achieving major reform. However, it would not address many of the fundamental problems with the current system, including the downward trend in the numbers receiving publicly funded care. Nor would it protect people against 'catastrophic' care costs.
- The Conservative Party's proposals would have, for some, resulted in a more generous system than the one currently in place. However, there are real concerns around implementing and operating such a complex system. There is also a question as to whether this would be the best use of additional funding for social care.
- While a joint health and social care budget might support progress towards more integrated care, it will not in itself address the differences in eligibility between the two systems, or generate additional revenue for health or care.
- Free personal care would mean increasing the government's 'offer' on social care. However, given this would require an increase in public spending, there is a question as to whether this would be the best use of additional funding for social care.
- A hypothecated tax may help gain public support for raising additional funding for social care. However, this would represent a significant shift from the existing system, and could exacerbate the lack of alignment between the health and social care.

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Introduction

It is widely accepted that the system for funding social care is in urgent need of reform. Faced with shrinking budgets, local authorities are struggling to meet the growing demand for care, linked to increasing complexity in need and an ageing population. As a result, the number of older people receiving publicly funded social care has declined. While in practice, much of this shortfall has been met by private spending and informal care; it is also likely that many people's care needs are going unmet.

There is little sign of a long-term solution on the horizon. For those who have watched the progress of the social care system over the years, this is a familiar disappointment. Since 1998, there have been 12 green papers, white papers and other consultations, as well as five independent commissions, all attempting to grapple with the problem of securing a sustainable social care system. It has been called 'one of the greatest unresolved public policy issues of our time'.¹

The last government-established review of social care was the Dilnot Commission, which reported in 2011. However, plans to implement the Commission's key proposal – a cap on the maximum cost of care a person might pay in their lifetime – were abandoned by the government in December 2017.² The social care system remains unclear to the public.

In 2016, in the face of widening public and political pressure over perceived underfunding for social care, and increasing concerns over the impact on the NHS, the government made available an extra £2bn of funding over 3 years for local authorities in its spring budget. This followed the introduction of a social care 'precept', enabling local authorities to raise additional income for social care from council tax, and increased funding through the Better Care Fund. While these moves were welcomed, they were widely seen as a sticking plaster with which to patch up social care until a longer-term solution to funding could be found.

Social care became a key general election issue in 2017 when the Conservative Party proposed to reform the means test and, in the face of widespread criticism, was forced to amend its proposals (in particular by promising an 'absolute limit' on the costs any individual would need to pay). A green paper on care and support was also promised, and its publication is now expected in the summer of 2018.³

While the debate around social care funding involves many technical issues, it is important not to lose sight of the huge significance of this care for those in need of support, and for their families. Social care is critical in helping people to live independently and in protecting them from harm in situations where they are vulnerable. As the system struggles to manage the growing demand, both financial and human costs are mounting.

Against this background, the Health Foundation and The King's Fund are undertaking work exploring options for the future funding of social care. The next section provides an overview of the wider project, as well as the work covered by this working paper.

The history of social care funding

England's system for funding social care (set out in the section, *The current system for funding social care*) has its origins in 1948, when the National Assistance Act came into effect, giving local authorities responsibility for what we describe today as social care on a means and needs-tested basis. The NHS – a national service, funded from general taxation and free at the point of use – was established in the same year, and the divide between the two systems has remained in place ever since.⁴

However, since 1948 the boundaries between the two systems have been less fixed than is often assumed. With the shift of care out of institutions and into the community, the accommodation costs associated with social care were transferred from the NHS into the means-tested benefits system. This led not only to a growth in private and voluntary care homes, but also to a decline in long-stay beds in the back wards of NHS hospitals. People were instead shifted out of free NHS care into means-tested residential and care homes – a large-scale, yet unplanned change that was never subject to public debate.⁵

These changes also meant an explosion in the cost of social care falling on the social security budget with spending increasing from £10m to £2.5bn between 1979 and 1992.⁵ This increase was one of the main drivers behind a series of community reforms in the 1990s, which aimed to contain costs and promote care at home.⁴ Following the 1988 Griffiths Report, the 1990 NHS and Community Care Act transferred social security spending to local authorities and gave local authorities the lead role in assessing people's needs for care in all settings and arranging care. They were expected to promote a 'mixed economy' of social care provision and this confirmed the trend for most social care services to be provided by private and voluntary organisations.⁶

Since the late 1990s the focus has been on financial sustainability.⁴ Table 1 sets out key government-led initiatives since 1999.

Table 1: Timeline of key government-led initiatives in social care since 1999

1999/2000	The Royal Commission on Long Term Care's report, <i>With Respect to Old Age</i> , ('Sutherland Report'), is published in 1999. In 2000, the government rejects the Commission's proposal for free personal care, but does agree to amend the means test, introduce free NHS nursing care in care homes, and to invest in new services.
2002	Sir Derek Wanless is commissioned by HM Treasury to carry out an independent review of NHS spending. He recommends a more thorough assessment of social care funding needs, but this is not acted on (although The King's Fund subsequently commissioned Wanless to carry out a review into the long-term demand for and supply of social care for older people in England).
2005/06	A green paper <i>Independence, Wellbeing and Choice</i> is published in 2005, setting out a new vision for adult social care. This is followed by the white paper <i>Our Health, Our Care, Our Say</i> in 2006, which includes no specific funding proposals.
2009/10	In 2009, a green paper <i>Shaping the Future of Care Together</i> is published, launching the 'Big Care Debate', a public consultation on how social care should be funded and organised. This is followed by a white paper, <i>Building the National Care Service</i> , in 2010. A bill that would offer free personal care at home for those with highest needs, passes in 2010 but, with the change of government in that year, is never implemented.

2010/11	In 2010 the Dilnot Commission is appointed to make recommendations for an 'affordable and sustainable' system for care and support. The Commission's report, <i>Fairer Care Funding</i> , is published in 2011, recommending changes to the means test and a capped cost model.
2012	A white paper, <i>Caring for our future: progress report on funding reform</i> , and a draft Care and Support Bill are published by government. The government also says that it is committed to the principles of Dilnot proposals, if way can be found of funding them.
2013	The government announces the introduction of social care funding reforms, including the capped cost model, from April 2016. The budget brings forward implementation of the capped cost model to 2016. The government places the Care Bill, incorporating clauses to implement the Dilnot proposals, before parliament.
2014	The Care Act, including funding reforms (such as the capped cost model and changes to the means test) receives royal assent.
2015	The government announces the postponement (until 2020) of the funding reforms. In the Spending Review and Autumn Statement, the government announces additional money for social care through an improved Better Care Fund and a new power enabling local authorities to levy a council tax 'precept'.
2017	The government announces an extra £2bn for social care over the next 3 years. A green paper on care and support for older people is announced by the government, to be published in the summer of 2018. The government announces that it will no longer be taking forward plans to implement a capped cost care model by 2020.

Adapted from: Paying for social care: Beyond Dilnot.⁴ A short history of social care funding: 1996 to 2017⁷

An overview of adult social care in England

This section provides a high-level overview of the adult social care sector in England. This provides important context for our work on funding, but is not intended to be a detailed discussion of the other issues facing the social care sector.

Social care is the personal care and support required by some people because of needs arising from their age, illness, disability or other circumstances. Support is provided in residential and nursing homes, people's own homes and in other community settings.

Demand

Demand is growing as the population ages and more people live for longer with multiple long-term conditions, such as physical disabilities and dementia. The number of people aged 85 and over in England is set to increase from 1.3 million in 2014 to 2.1 million in 2030.⁸ Younger people with disabilities are also living longer: life expectancy for a person with Down's syndrome has increased from 23 in 1983 to 60 today.⁹

Finances

(Details of the current funding system, and what this means for those receiving social care services, are set out in the next section.)

In 2016/17, total spending by local authorities on adult social care was £14.9bn, excluding the Better Care Fund (BCF), or £16.8bn including the BCF (nominal).¹⁰

Quality of care

Care is of variable quality. In 2017 the Care Quality Commission (CQC), which inspects providers, rated around 1 in 5 providers as 'requiring improvement' or 'inadequate'. Overall, 78% of care was judged good and 2% outstanding.¹¹

Community social care services had the highest ratings (86% good or outstanding), while nursing homes were identified as the greatest concern, with only 70% rated good or outstanding.¹¹

There is widespread public concern at perceived neglect and abuse in social care services. In recent years the media has reported several cases of families using 'hidden cameras' to collect evidence of their relatives being abused while in care.¹²

Providers

There are an estimated 20,300 organisations providing social care services, delivering care from around 40,400 'establishments' (which include individual care homes, shared lives services and domiciliary care services).¹³ The great majority are in the private or not-for-profit sectors.

Around 80% of residential and nursing care providers are small and medium-sized businesses, with a small number of larger companies making up the remainder. There is very high turnover of domiciliary care providers, with around 500 new entrants every quarter offsetting 400 cancelled CQC registrations.¹¹

Market developments

Providers of social care are increasingly showing signs of strain, with companies handing back contracts and/or leaving the market. The risk of provider failure on a large scale seems high:¹⁴

- A survey of directors of adult social services found that 69% of councils had been affected by provider failure in the last 6 months; 44% had residential/nursing care providers which had closed or ceased trading, and 39% had experienced this with home care providers.¹⁵
- In the last 2 years, two of the biggest national providers of home care (Saga and Care UK) have withdrawn from the publicly funded market, and two others (Mears and Mitie) reported operating losses in their home care divisions.¹⁶
- The number of residential and nursing home beds has fallen slightly in the last 2 years, although this varies widely between regions.¹¹ A recent Competition and Markets Authority study concluded that many care homes are not in a sustainable position; local authority fees are on average 10% below the total costs for these homes, and those with over 75% of their residents funded by local authorities – roughly a quarter – are particularly vulnerable.¹⁷

- In 2011, major care home provider Southern Cross went into liquidation and in 2017 another, Bupa Care Services, left the market (in both cases the homes were purchased by HC-One). More recently, the CQC was involved in ensuring a 'standstill agreement' was reached between care home provider Four Seasons and its biggest creditor, delaying a major debt repayment that threatened continuity of care.¹⁸

Workforce

It is estimated that **in 2016 there were 1.6 million adult social care jobs in England**, an increase of 19% since 2009.¹³ Were they to increase in line with population projections, the number of social care jobs would rise by 500,000 by 2030.¹³

In 2014, The Kingsmill Review of the social care workforce found that many care workers were being paid less than the national minimum wage.¹⁹ A review by Skills for Care in 2016 suggested that around a quarter of the total workforce is on zero hours contracts (as are nearly half of workers in home care services).¹³

Staff turnover is over 25% as employers struggle to recruit and retain staff, and 6.6% of posts (around 90,000) are vacant at any one time.²⁰ The UK's departure from the European Union may also impact the availability of social care staff.²¹

The paid workforce supplements 'informal' care provided by individuals' friends and families. **In 2011, it was estimated there were 5.4 million unpaid family carers** in England.²²

Relationship with other public services

Social care services sit alongside – and sometimes overlap with or run in parallel to – several other public services. As well as the NHS, these include the benefits system, housing and support for the homeless, the police and criminal systems. The interface with these services is important for people receiving social care, particularly those of working age. Those receiving social care are often in receipt of other benefits, such as the attendance allowance and disability living allowance (see next section).

As set out above, the separation between health and social care services dates back to 1948, when the NHS was introduced. The longstanding divide between the two systems is particularly stark in the context of NHS continuing health care (CHC), which provides support to people with ongoing health needs. While those assessed as eligible for CHC (see below) receive their care for free, those who do not meet the criteria receive social care on a means-tested basis – and therefore may be required to pay some or all of the costs themselves. As such, decisions over CHC eligibility can have a significant impact on people's finances.²³ This boundary – and the 'cliff edge' between those who have to pay for their care and those who do not – can be a cause of significant distress for families seeking support for their relatives, and over the years has led to a number of court judgements.⁵

Box 1: NHS continuing health care

NHS CHC is out-of-hospital care provided to adults (over 18) with significant ongoing health care needs. CHC, which can include health and social care, is arranged and funded solely by the NHS.

Eligibility for CHC is determined by clinical commissioning groups (CCGs), according to a national framework set by the Department of Health. The framework states that eligibility should be determined on the basis of health care needs, rather than diagnosis.

In 2015/16, nearly 160,000 people received or were assessed as eligible for CHC funding.²³

Integration of the NHS and social care has been a longstanding aim and the current government plans for the two to be integrated in England by 2020. However, a National Audit Office report in 2017 found less progress had been made than expected.²⁴ One symptom of this difficulty is delayed transfers of care from hospital to social care, which have increased significantly since 2014.

Methods

The aims of our project were to identify a range of alternative approaches to the broad challenge of funding social care, and to set out the implications of each. Our objective is not to put forward a single recommendation, but to set out a range of potential options and their relative strengths and weaknesses when assessed against a clear set of attributes.

The overall project comprises the following workstreams:

- **Options generation** – to identify some possible approaches to funding social care, the first findings of which are set out in this paper
- **Modelling demand for social care** – to project demand for social care over the medium-term
- **Modelling of options** – to determine financial implications of alternative options
- **Tax benefit analysis** – to look at ways of raising additional revenue through taxation
- **Public engagement work** – to understand public attitudes to social care and different approaches to funding. This work will comprise:
 - a discrete choice experiment and work exploring international models of social care
 - analysis of data from the British Social Attitudes survey
 - a series of deliberative events with the public.

This working paper sets out the findings of the first phase of the project. It provides the background to our work, describes the attributes we considered when exploring the different options for funding, and assesses a range of possible approaches that are the subject of current debate around social care (the rationale for focusing on these approaches is set out in the section, *Comparing approaches to funding social care*). The final section of the paper sets out our conclusions on the different approaches, and describes the next phases for the wider project. The approaches covered in this report are:

- improving the current system (through marginal changes)
- a hypothecated tax for social care (encompassing social insurance models)
- a single budget for health and social care
- the 2017 Conservative Party proposals
- free personal care, similar to the system in Scotland.

A final report bringing this work together with the outcomes of the other workstreams will be published later in 2018.

Scope of our work

The work set out in this paper is focused on adult social care for older people in England. More detail on the scope of the project, and the reasons for structuring the project in this way, are set out below.

Funding

The debate around social care funding incorporates several issues, including the extent to which costs are shared between the state and the individual (and how the state share is funded), and the way in which funding is organised to achieve the best outcomes. These issues are often bound up with others such as the quality of care and choice for service users, as well as much wider issues, such as local government finances and the workforce.

The scope of our work is restricted to approaches to funding social care. The specific issues we are exploring are set out in the section, *Designing a model for funding social care*.

International models

This paper does not explore any models for funding social care outside the UK, although some of the approaches discussed have been adopted in other countries. This is because, as part of the wider project (described above), RAND Europe is exploring evidence on reforms to health and social care funding models, and highlighting lessons for the UK.*

Other work in this area includes The social care and health systems of nine countries,²⁵ Measuring social protection for long-term care²⁶ and Long-term care reforms in OECD countries.²⁷

Services for people of working age

Although the social care system provides a wide range of support to adults of all ages, this interim report is focused on those aged over 65.

We have adopted this approach following an initial assessment of the circumstances (in particular, financial circumstances), of people of working age who receive social care. This is set out below:

* This work, led by RAND Europe in collaboration with the Personal Social Services Research Unit at University of Kent and the European Observatory on Health Systems and Policies, is due to be completed in June 2018. For more information see: www.health.org.uk/programmes/projects/funding-options-nhs-and-social-care-uk

Box 2: Social care services for people of working age

Service users

For those aged between 18 and 64, the most common reason for receiving long-term social care support is a learning disability (this was the primary reason for support for 45% in 2016/17). After this, the most common reasons were physical personal care support (23%), and mental health support (20%).²⁸

Spend on social care for working-age people

In 2016/17, long-term care (comprising residential, nursing and community care) accounted for just over three-quarters of gross current social care expenditure for people of all ages.

Expenditure on those aged over 65 and those aged 18–64 was similar, although the number of people over 65 receiving long-term care is much higher. One explanation for this difference offered by NHS Digital is that long-term support for those under 65 tends to be for more complex care needs, and consequently has a higher unit cost for nursing and residential care²⁸ (although it may also reflect a difference in the scope and quality of care packages provided). In contrast, in the case of short-term care, almost three-quarters of spending was on adults aged 65 and over.²⁸

A survey of local authorities indicates that working-age adults account for an increasing proportion of the pressure on local authority adult social care budgets.¹⁵ Net public expenditure is also higher for the former group, although projected growth in expenditure to 2035 is higher for older people.²⁹ The All Party Parliamentary Group estimated a £1.2bn funding gap in services for working-age people. They found local authorities have been tightening eligibility for working-age people and that care is increasingly focused on crisis intervention and unmet need is rising. They suggest a budget is needed for preventative care for working-age people.³⁰

Financial characteristics of this group

Unemployment levels are higher among disabled people than non-disabled people. In March 2013, the unemployment rate among disabled people was 12%, compared with 7.6% among non-disabled people.³¹ Data for 2016/17 shows that for adults with a learning disability (with this as the primary reason for support), the proportion in paid employment is 5.7%.³² Linked to lower employment rates, disabled people are more likely than non-disabled people to live in low income households.³¹

Disabled people also tend to have fewer savings than non-disabled people; research shows that 55% of disabled people report having no savings, compared with 12% of the general population, and on average disabled people have £108,000 fewer savings than non-disabled people.³¹ A study into financial issues for people with learning disabilities found that this group often lack financial autonomy, with parents and support workers taking responsibility for their money.³³

Research also points to lower levels of homeownership among disabled people of working age than among those over 65. Research into the market for accessible homes found that of the households that needed accessible housing, 1 million were owner-occupiers, of which only 230,000 were of working age.³⁴ Other research has found that most people (76%) with a learning disability known to local authorities live either with family and friends, in a registered care home or in supported accommodation.³⁵

This initial assessment suggests that, in general, working-age people who use social care services have very different financial characteristics to users aged over 65. As a result, while in the case of older people with social care needs there may be a wide range of options available for funding care, particularly those which draw on personal and property wealth, for working-age people we expect that a fully tax-funded solution will be the only appropriate solution. The focus on older people is also consistent with the approach the government is taking in the development of a green paper, to be published in the summer of 2018.

This is not to deny the challenges in funding care for working-age adults, which account for an increasing proportion of the pressure on local authority adult social care budgets. The next phase of our work will estimate the future demand and costs associated with social care for all age groups. For each of the models described we have, as far as possible, set out the implications for working-age people, or highlighted issues which would need to be considered further

Approach to the project

Objectives

The objectives of the first phase of work, set out in this report, are to:

- develop a list of attributes to consider when exploring possible funding options
- assess a set of approaches frequently discussed under the broad area of social care funding.

Development of attributes

The purpose of developing a set of attributes was to enable a comparison between the different approaches to funding identified. Throughout our work we have described these as ‘attributes’ or features, rather than as criteria, as they are not intended to be a set of pass/fail standards against which the different models are assessed. Rather, the attributes were used to help us understand the relative strengths of the different approaches, and to set out what the trade-offs might be when choosing between models. This has the advantage of not requiring a hierarchy of importance across the different attributes, many of which – such as equity – reflect value judgements.

Developing this list of attributes involved:

- Reviewing the outputs of previous reviews of social care, and other relevant literature, to compile a long list of the features previously considered in relation to models for social care funding. These were consolidated and prioritised by the project team (which included excluding those which did not relate to funding specifically), to provide a shortlist.
- Testing and refining the proposed shortlist through discussion with our stakeholder groups (see below), to produce a final list.

Development of funding approaches or narratives

The set of funding approaches discussed in this paper are intended to reflect the narratives or solutions most commonly raised in the context of funding social care. As such, these options do not represent a comprehensive or indeed, rational, list of the possible models for funding social care. However, between them they incorporate a range of features, enabling us to explore their potential implications.

Identifying these options included:

- A rapid review of the relevant literature to identify a long list of models. These were refined by the project team to focus on the approaches most prominent in the current debate around social care funding.
- Testing and refining these options with our stakeholder groups (see below).

Stakeholder engagement

We engaged with two stakeholder groups:

- One group comprised academics, researchers and others with expertise in social care and public finance. We met with this group twice during the project to discuss the attributes, and range of funding approaches, and to test our emerging conclusions on each of the approaches considered.
- A second group comprised user representative organisations and social care providers. We met with this group towards the end of phase one to test/seek feedback on our conclusions on the different approaches.

Engaging with the first stakeholder group helped us refine and consolidate the list of attributes to be used in evaluating the different options. Discussions with this group also provided additional insight into the strengths and weaknesses of the different approaches considered, and highlighted key issues around implementation. Engaging with the group of user representatives provided a further sense check on our list of approaches and assessment of these, and identified additional considerations and possible consequences relating to the different models.

The next section sets out the key features of the current system for funding social care.

The current system for funding social care

Funding

Within the current system, there is no national budget allocation for social care. Instead, adult social care is funded through multiple sources, including both public and private funding.

Core funding

Core funding includes:

- Funding from central government in the form of a **revenue support grant** (which is not ring-fenced), provided to local authorities.
- Income generated locally through **council tax and business rates**. The level at which these are set is at least in part at the discretion of individual local authorities, and the amount of income raised is linked to the council's tax base. The current policy intention is to end the revenue support grant by 2020, and for local authorities to be able to retain 100% business rate retention.
- Income from user charges.

Additional funding

In recent years, as the scale of the funding challenge has become increasingly apparent, the government has 'topped up' social care budgets at the margins. This has included:

- The **Better Care Fund (BCF)** – since 2013, central government has also transferred some NHS funding to social care through the BCF.
- A **social care precept** – giving local authorities the opportunity to raise additional income between 2016–17 and 2019–20, through a social care precept, or annual rise in council tax each year (by up to 6% over the period).
- An **adult social care support grant** worth £240m in 2017–18, distributed according to need.
- The **Improved Better Care Fund (iBCF)**, a grant paid directly to local authorities on the condition that they are pooled as part of the BCF. The iBCF was announced in 2015, and allocations were increased in the 2017 spring budget.

Box 3: Local authority revenue and expenditure in 2016/17³⁶

Revenue^{*}

- Total local authority revenue was **£51.56bn**, of which:
 - £22.37bn (45%) was from council tax
 - £11.39bn (23%) was from retained business rates
 - £15.96bn (32%) was from grants – this excludes the BCF, which was an additional £1.85bn.

Spending[†]

- Total spending on services, including the BCF, was **£45.62bn**
- Spending on social care, including the BCF was **£16.8bn**

It is also important to highlight some other benefits paid to many of those receiving social care services – Boxes 4 and 5 describe attendance allowance and disability living allowance:

Box 4: Attendance allowance

Attendance allowance is a cash benefit administered by the Department for Work and Pensions (DWP) that is payable directly to older people with care needs. This is paid at two rates, according to the person's level of need.³⁷

In 2016/17, expenditure on the attendance allowance in England was £4.7bn (nominal).³⁸

The government raised the possibility of transferring the attendance allowance to local authorities as part of a range of reforms to business rates, but has since stated that this is no longer being considered.

^{*} Grants measure includes Specific grants inside AEF, business rates supplement, local services support grant and the revenue support grants. From specific grants we exclude grants for education, police and fire. The revenues figure is greater than the spending number because local authorities spend in areas other than on services (eg debt interest and repayment of principal, use of resource budgets for capital investment), and because it is not possible to fully strip out revenues for services that have been excluded from the spending measure.

[†] Total service spend excludes spending by police, fire and national park authorities. Includes spending by the GLA. By those authorities included in the measure, we exclude spending on police, fire and education.

Box 5: Disability living allowance

The disability living allowance (DLA) is a benefit provided to disabled people of all ages to support them with mobility or care costs. Like the attendance allowance, the DLA is administered by DWP.³⁹ The DLA system is currently changing, with those aged 16 to 64 being moved to personal independent payments.

In 2016/17, expenditure on the disability living allowance in England was £9.5bn. Of this, £4.3bn was spent on people of working age and £3.6bn was spent on pensioners, with the remainder spent on children (all nominal).³⁸

Moving people to the personal independence payment was initially expected to reduce overall spending due to changes in the eligibility assessment. However, more recent analysis suggests that both the number of people receiving payments, and the average amount paid, will be higher than expected – resulting in a higher overall spend.⁴⁰

In addition to these benefits, in 2016/17 the government spent £2.3bn on carers allowance – which supports those with caring responsibilities for more than 35 hours a week – in England.³⁸

Management of social care funding

Central funding is allocated by the Ministry of Housing, Communities and Local Government to upper tier and unitary local authorities through the revenue support grant. Councils decide locally how much of this grant should be spent on social care. This is supplemented by the other sources of funding set out above.

These arrangements are entirely separate from those in the health sector, where central funding is allocated to local CCGs and other commissioners, and to the benefits system, which is administered by the DWP.

Eligibility criteria

Within the current system, publicly funded social care is provided to those who qualify according to two criteria, set out below.

Needs test

The Care Act 2014 introduced a national minimum eligibility threshold, which is implemented by local authorities. This was intended to be similar to the level of 'substantial' need under the previous 'fair access to care services' criteria.

The eligibility threshold is intended to provide some consistency in the way that eligibility is determined in different areas across the country, such that people with needs above a certain level can expect to be identified as eligible for care, regardless of where they live. Local authorities cannot restrict eligibility beyond the defined threshold.

Assessments must be carried out by appropriately trained assessors. The threshold requires local authorities to provide support to those who, as a result of an impairment or illness, cannot achieve at least two outcomes in their daily life, resulting in an impact on their wellbeing.

Means test

With the exception of information and advice, and a range of safeguards (for example, for those with care and support needs experiencing abuse or neglect) social care is means tested, as follows:

- There is a **lower means test, set at £14,250** – those with assets below this level are not required to contribute to the cost of their care.
- There is also an **upper means test, set at £23,250** – those with assets above this level receive no support, and are expected to meet the full costs of their care themselves. In the case of residential care, the person's housing assets are taken into consideration as part of the means test, but in the case of domiciliary care they are not.
- Those with assets between £14,250 and £23,250 are expected to make some contribution to their care. This contribution, or 'tariff income', is calculated on the basis of £1 per week, for every £250 of assets above the £14,250 minimum.

Most of the discussion around the means test relates to people's assets. However, it is important to remember that people's incomes are also part of the means test: people who are cared for in care homes are expected to contribute their income to the cost of their care, down to the level of the personal expenses allowance, which is currently £24.90 per week. Historically the focus on assets rather than incomes arose because many recipients were on low incomes, either because they were reliant on the state pension or as younger age adults had no significant source of income. For many with potentially more generous final salary pensions this may no longer be the case.

Box 6: Deferred payment agreements

Under the Care Act 2014, local authorities are required to offer deferred payment agreements (DPA) to people for whom they arrange care, and for people who arrange and pay for their own care in a care home, who qualify for means-tested support. (Local authorities are also encouraged to offer the scheme more widely to those who may benefit).

DPAs enable people to delay paying the costs of their care, including until after their death, with the aim of preventing people from having to sell their home during their lifetime to pay for social care. However, there is evidence that in practice provision of DPAs varies significantly between local areas.

What this means for service users

The arrangements set out above mean that there are three groups of users:

- those whose care is fully funded by the local authority
- those who pay for the full costs of their care themselves, either because they do not qualify for local authority funded care, or because they choose not to take it up
- those whose care is funded by a mixture of local authority payments and self-payments, or third party top-up payments. Top-up payments are made by a third party (typically the person's relatives) when someone chooses to receive care from a provider that charges more than the rate paid by the local authority.

Available data suggests that in the case of care homes, just over half of users (in the UK) are paying for the full costs of their care, or making some contribution in the form of top-up payments. As Box 7 explains, in the case of domiciliary care, most are receiving publicly funded care.

Box 7: Sources of funding for users of social care

Care provided in care homes

- LaingBuisson estimate that in 2016, there were 392,000 people in independent care homes (both for-profit and not-for-profit) in the UK, which account for the vast majority of care homes. This figure includes nursing care and residential care residents.
- Of these:
 - 44% (172,000) were self-funded
 - 35% (138,000) were funded by the local authority
 - 12% (48,000) were part funded by the local authority, and also making top-up payments
 - 9% (34,000) were funded by the NHS.⁴¹

Domiciliary care

- The United Kingdom Homecare Association estimates that in 2014/15, 874,000 people received domiciliary care across the UK. Of these, 646,000 people (74%) received publicly funded care, while 228,000 people (26%) paid for their care privately.⁴²
- In England, 465,050 people received state-funded domiciliary care in 2014/15.⁴¹ If the breakdown between those receiving publicly funded care and those who pay for their own care in England is similar to that across the UK, it can be assumed that around 164,000 people received privately funded care. This would suggest a total of around 629,000 people receiving domiciliary care in England in 2014/15.

Publicly funded care

Since 2010 local authorities have spent less on social care as they managed a 38% fall in their overall grant from central government.⁴³ Between 2009–10 and 2015–16, spending by councils on social care per adult resident fell by 11% in real terms,⁴⁴ and over the same period the number of people receiving publicly funded social care services fell by 400,000.⁴⁵

This is linked to a tightening of eligibility criteria, such that care is focused on those with very high levels of need, while the means test has remained largely unchanged. This has meant that (in the context of a growth in pension and property wealth) only those with relatively low means are entitled to publicly funded care. Prevention and early intervention have become increasingly squeezed.

More recently, spending on social care began to rise slowly, largely as a result of the new social care precept. However, there has been limited change in activity over this period, suggesting that the additional investment is not enough to keep pace with growing demand and costs. It is estimated that by 2019/20 there will still be a social care funding gap of £2.5bn.⁴⁵

Self-funded care

Those who do not qualify for state-funded care are able to buy care privately. For some of those people, the costs of paying for care can be very high: in 2011 the Dilnot Commission estimated that at age 65, 1 in 10 people – typically those who spend several years in a care home – will face ‘catastrophic’ care costs of more than £100,000.⁴⁶

Over time, as public sector spending on social care has been constrained below the increases in demand, the proportion of spending accounted for by private individuals has increased. The proportion of self-funders in independent sector care homes increased from 40% in 2007 to 44% in 2016.⁴¹

Informal care and unmet need

Those who do not qualify for care funded by their local authority (or are unable to access it) and are unable to pay for it themselves are often reliant on informal care. More families and friends are providing care to relatives and neighbours than ever before – the number increased from 4.9m in 2001 to 5.4m in 2011 and is expected to reach 9m by 2037.²² Politicians such as Jeremy Hunt and David Mowat have suggested that part of the answer to the growing demand for social care services is more informal caring on the part of family.⁴⁷

It is also likely that there is some unmet need – defined as people not receiving care, despite being unable to perform at least one activity of daily living. Age UK estimated that there were over a million people with unmet needs in 2017.⁴⁸

Designing a model for funding social care

The debate on social care funding often includes a number of separate issues. Three of the most important, which we explored in our work, are as follows.

- What is the government responsible for? Or, where does the balance of responsibility (in terms of costs and risk) lie between the state and the individual?
- How does government finance its social care spending? Where does the money come from?
- How is social care finance allocated and organised?

This section sets out the key questions which need to be addressed in developing an approach to funding social care, and describes some of the options in each of these areas. The purpose is to illustrate how the models considered in this paper fit in to the overall debate, before we go on to describe them in more detail in the following sections.

What is the government responsible for?

At the heart of the debate on social care funding is a question about where the balance of responsibility lies between the state and public services, and the individual and their families. The decision on this principle will determine what the government offers in terms of social care (how much, to who, in what circumstances), and is linked to questions about equity, fairness and entitlement to care. It will also determine the scale of public funding required, and the level of cost, and risk, that will fall to the individual and/or their families.

Possible approaches range from models in which all (or the vast majority) of care is paid for by the state (generated through taxation), to ones in which people are expected to meet the full costs of their care themselves. The former could mean a model similar to the NHS, in which nearly all care is funded by the state, with people making out-of-pocket payments for only a small number of services. The latter is likely to mean a system in which the vast majority of care is paid for by the individual and/or their families. In practice, this is also likely to mean more care provided by families and informal carers as well.

As shown in the previous section, the current system sits between these two extremes, relying on a combination of public and private funding (see Box 7). Our **improving the current system** scenario (see section, *Five approaches to funding social care*), assumes that there is no change in the overall structure of the system for funding social care and consequently, as in recent years, the number of older people receiving publicly funded care will reduce over time.⁴⁵ There is a risk that, without more substantial reform, our current system will move further towards a 'privately funded' system, with private spending increasing as a proportion of overall spend. In this scenario, publicly funded support would increasingly be a 'safety net' for those with the highest needs and lowest means, and focused on essential needs rather than inclusion, occupation and social and psychological needs.

The model set out by the Dilnot Commission, and **the Conservative Party's proposals** at the time of the 2017 general election (set out in its manifesto and in other statements) – another one of the models considered in this paper – also rely on a combination of public and private funding. The Conservative Party Manifesto proposed introducing a more generous means test, although it also suggested that, for the first time, the individual's home should be taken into account in this test for those receiving domiciliary care. Subsequently, the Conservative Party also proposed a cap on care costs. Together these changes represented a broadening of the government's offer on social care, reducing the level of cost borne by individuals. As a result, if put into effect, the cost of social care to the government would be much higher than it is now.

Another of the approaches discussed in this paper, **free personal care**, would also mean an increase in the government offer compared with the current system. This model, which has been adopted in Scotland, distinguishes between personal care tasks and other social care support, providing the former to everyone over the age of 65 who needs care in their homes for free, on a non-means-tested basis. As with the Conservative Party proposals described above, this would mean an increase in public spending on social care.

How is it funded?

Public funding

Assuming that at least some social care costs are met by the state, there is a question as to how this share is funded. In practice, this will mean drawing on income from taxes, although the form this taxation takes could vary.

As set out in the previous section, within the current system and under our **improving the current system** scenario, the state's contribution to social care costs is funded through multiple sources.

Hypothecation, one of the approaches explored in this paper, represents an alternative tax-funded approach. Rather than drawing on revenue from general taxation, hypothecation would mean introducing a dedicated tax to meet the costs of social care. This approach could take different forms (see section, *Five approaches to funding social care*), including a social insurance model in which individuals pay a contribution (possibly via their employers) to receive a defined package of social services. New forms of wealth or property tax, including the concept of a 'death tax' – levying a tax for social care on people's homes after they die – could also constitute a form of hypothecation. The social care precept introduced in 2016, which allows local authorities to raise additional income for the specific purpose of funding social care, is also a form of hypothecation.

A different approach to addressing the shortfall in social care funding (or funding a broader government offer) would be to redirect other elements of spending on older people to support social care services. Examples include the winter fuel allowance, attendance allowance and free TV licences for those over 75.⁵ Removing the triple lock on pensions, as proposed by the Conservative Party in its 2017 manifesto, would also release funding which could be directed to the social care system. These changes do not, of themselves, alter the 'offer' to the public on social care, they simply make more money available whatever the offer should be. In reality, the public may not separate these two issues so clearly – if they

pay more in taxes (or lose existing benefits) they may only do so if they think the 'offer' is better.

Private funding

The individual's contribution to social care costs could also take different forms. As discussed in the previous section, in the current system, many people make payments to social care providers directly, for the full costs of their care or in the form of third party top-up payments.

Under the Care Act 2014, local authorities are required to offer DPAs enabling people to delay paying the costs of their care, including until after their death, to prevent them having to sell their homes in their lifetimes to pay for social care. However, there is evidence that in practice provision of DPAs varies significantly between local areas.

Equity release schemes are another mechanism through which people can draw on the value of their home to pay for care, without having to sell it or move before they wish to.

There are few private insurance products available to people who might want to insure themselves against future care costs. Indeed, although the Dilnot Commission's recommendations were predicated on the development of an insurance market for social care,⁴⁶ in practice this has not developed. The main product which is available – an immediate needs annuity – is usually taken out by people about to enter a care home and, in return for a lump sum, pays all future care home fees. They are, however, very expensive, costing around £69,000 on average.

Savings products have also been proposed – though not yet legislated for – that would grant people tax benefits to save for future care costs.

How is funding administered?

A third aspect of the system for funding social care is the way in which it is administered. This relates to the management of funding within the system, at both a national and local level.

Currently, grant funding is allocated by the Ministry of Housing, Communities and Local Government, and councils decide locally how much of this grant should be spent on social care. These arrangements are entirely separate from those in the health sector, and the benefits system.

One of the approaches set out in this paper is a **single health and social care budget**, which would represent a significant change in the current mainstream model. This would mean pooling budgets for health and social care at a local level. Some parts of England have already experimented with this approach, such as Greater Manchester. The establishment of a single health and care budget might also be an opportunity to bring together some of the other funding streams which support those with care needs, such as the attendance allowance.

Comparing approaches to funding social care

There are a number of factors to consider when exploring options for funding social care. Although the approaches set out in this paper address different aspects of the challenge around the funding and delivery of care, it is helpful to consider the implications of each using a common framework.

We have not attempted to develop a set of 'objective' criteria to enable the different approaches to be ranked. Instead we have reviewed the approaches according to a common set of parameters, to help us understand the implications of each model, and identify what the trade-offs might be when choosing between them. These parameters include a set of attributes commonly discussed in the context of models for social care funding, issues relating to the implementation of the different models, and considerations for people of working age with social care needs. Each of these are set out in more detail below.

Model attributes

Table 2 sets out some key areas, or attributes, which are relevant in the design of any model for funding social care. Within each of these areas we have identified some key questions to be considered.

Of course, while the approach to funding may have an influence in the areas set out below, a funding system in itself is unlikely to provide an answer to all of the questions given. When considering these issues in relation to the funding approaches set out in this paper, we have therefore considered the extent to which the funding system may support (or inhibit) a particular attribute.

Box 8: The challenges of implementation

The main change we have made to the criteria or attributes used by other reviews is to place greater emphasis on the costs of implementation and change.

This is because the combination of poor public understanding of social care (particularly where some of the public confuse social care with the far more generous NHS), combined with high political and economic costs of implementation and change, has led many governments to avoid grasping the challenge of social care funding.

Table 2: Key attributes for designing a model for funding social care

Equity/ fairness	<ul style="list-style-type: none"> • Does the entitlement to financial support need to be the same in all parts of the country? • Does the system offer equal support and treatment for equal needs (regardless of whether they are 'health' or 'care' needs)? • What are the implications for fairness within and between generations? To what extent should the social care system seek to address these issues, separately from wider government policy? <ul style="list-style-type: none"> – Should financial support take into account income/ability to pay, or need only? – What proportion of people's assets and income is it fair for the system draw on? • How far, if at all, does the system protect people from very high care costs? • Does the system enable people on low incomes and with modest assets to access the care they need? • Does the system provide an equitable quality and quantity of support across age groups and other characteristics?
Economic efficiency and value for money	<ul style="list-style-type: none"> • How well does the system support best outcomes compared with alternative uses of health, housing and social care resources? • Does the system offer value for money to taxpayers? • What are the implications for the wider economy (eg costs of informal caregivers exiting employment)? • What are the transition and implementation costs? • What are the ongoing low transaction costs? Or, how much does the system cost to administer?
Sustainability/ resilience	<ul style="list-style-type: none"> • How well does the system adapt to changes in need – ie what scope is there for making changes for future needs without undermining the whole system? • What implications are there for the sustainability of local government finance? • How well does the system provide a stable basis on which funders, providers, insurers, users and carers can plan? • How well does the system fit with operational issues, including developing a trained workforce and suitable housing stock? • Does the system support a stable care market able to provide dignified care and support safely?
Acceptability/ accountability	<ul style="list-style-type: none"> • How far does the system command public support, both in the long term and from winners and losers in the short term? • How well does the system integrate with other related public services? • How well does the system provide accountability to the public/tax payers?
Ease of use/ clarity and service user needs	<ul style="list-style-type: none"> • Is the system capable of being widely understood/easily accessed by users/the public? • How far does the system provide for choice?
Cross cutting themes	<ul style="list-style-type: none"> • Should the funding system encourage/support some level of informal caring – ie promote some responsibility from individuals and families? • Should the system reward/encourage people to make their own provision to a 'reasonable' extent? • Should the system reward/encourage actions that reduce the amount of care needed – now and in future? • How far does the system support closer working between health and social care?

Intergenerational fairness

There is a current, high profile debate around not only the appropriate balance of public and private funding for social care, but how these costs should be distributed between generations. With the number of older people rising, and the relative number of younger people – who bear much of this cost through taxation – falling, many are concerned that inequity between generations is increasing. Indeed, the distribution of income has changed in recent decades, and as a group, older people now own a large share of the housing wealth in England.

This narrative appears to be widely supported: analysis of 30 years of British Social Attitudes data shows that support for public expenditure for people who have retired has declined in recent years (although people still support government spending in this area).⁴⁹ It was also reflected in the Conservative Party Manifesto, which promised ‘a restored contract between the generations’, including through the social care system⁵⁰.

There is an important question about the extent to which the social care system should be expected to address the issue of integrational fairness, as arguably this is a much wider issue, to be considered across government policy. Given the above context, however, it is not unreasonable to assume that the social care system could help tackle this issue, both in the way that public funding is generated, and in the way that support is distributed through the means test.

Implications for people of working age

As discussed earlier in this paper, our initial assessment suggests that a tax-funded solution is likely to be the most appropriate option for this group, and therefore the focus for our work is social care for older people. However, for each of the models described we have, as far as possible, set out the implications for working-age people, or highlighted issues which would need to be considered further.

Five approaches to funding social care

In this section we outline five of the most commonly raised alternative approaches in the context of funding social care:

- **improving the current system** – ‘as now’, continuing without significant reform of the social care funding system
- **hypothecation** – introducing a dedicated tax for social care
- **a single budget** – aligning our health and care systems with a joint budget
- **the Conservative Party proposals**, set out at the time of the 2017 election – making changes to means testing and introducing a cap on care costs for individuals
- **free personal care** – removing means testing to provide free personal care for all.

Below we describe each of these in detail, including who has proposed them and their strengths and weaknesses in relation to the attributes described in the previous section.

Improving the current system

Box 9: Key features of this approach

- This approach would mean **retaining the current system** for funding social care, with no fundamental change in the sources of funding (public and private), or the eligibility criteria (a needs and means test) which determine who receives publicly funded care.
- However, it does envisage smaller, incremental changes to the system, broadly in line with the approach taken in recent years – such as measures to ‘top up’ funding on a short-term basis.
- It also considers other incremental changes that could be introduced to improve issues such as eligibility for funding, for example reintroducing an annual increase in the means test in line with inflation.
- Given this approach would mean retaining the existing structure, there would be **no need for a transition or implementation phase**.

What is it?

This option would mean retaining the existing social care system but, in line with the approach taken to date, seeking small improvements and adjustments over time. (As per the recent announcement, it assumes that the recommendations of the Dilnot Commission, as set out in the Care Act, are not implemented.²⁾)

It recognises that while the current system has many critics, it has proved remarkably durable and – in the absence of a clear alternative and the political capacity to implement it – in practice may survive for the foreseeable future. This approach may be more realistic than additional attempts at major reform, which to date have not resulted in any fundamental change.

There are several areas in which the government could refine or improve the current system without making any changes to legislation or introducing large-scale reform. This scenario assumes that the government makes small changes in the following areas:

- amount of funding
- eligibility for publicly funded services
- integration with other services
- sharing and spreading innovation and best practice.

Amount of funding

There are various funding levers that the government could use to ease the current pressure on social care funding at local level, without significantly changing its approach to funding. These include:

- increasing the amounts available to councils through the BCF
- relaxing the restrictions on raising additional local income, most obviously by allowing more income to be raised through the social care precept (currently limited to an increase in council tax of 6% until 2019/20)
- increasing the amount available in the adult social care support grant (worth £240m in 2017/18) and extending it into future years
- encouraging the use of private funding, for example through the use of tax reliefs, or the creation of other incentives.

Eligibility – means test

The means test to access publicly funded social care has become progressively less generous since 2010 because the thresholds have not been uprated in line with inflation. The government could improve eligibility and bring more people into the publicly funded system by reintroducing an annual increase in line with inflation. It could be even more generous by introducing a more substantial increase along the lines of that in Wales, where the upper limit already stands at £30,000 and will go up to £40,000 in 2018. An even larger uprating – to £100,000 – is discussed below under the Conservative Party's proposals (although these proposals involve including the value of housing in assessments for home care as well as residential care). However – as with other potential improvement to the current system discussed in this session – any such move would need to be balanced by increased funding if it were not to place additional pressures on local authorities.

Eligibility – need

The Care Act 2014 introduced a national minimum eligibility threshold which was intended to be similar to the level of 'substantial' need under the previous fair access to care services criteria. Campaigning organisations argue that this leaves many older and disabled people unable to receive publicly funded social care services. The government could conceivably revise the Care and Support (Eligibility Criteria) Regulations to allow more people to receive publicly funded care. Again, such a move would have to be supported by additional funding to councils.

Integration

A consistent criticism of the current system of funding (and delivering) social care is that it is not integrated with other systems, particularly health. Rather than adopt the more radical solution of establishing a joint budget for health and care nationally and locally (see 'Single

budget for health and social care' below), the government could continue to promote integration of local services through NHS England's sustainability and transformation partnerships and support for integrated care systems. Although this is unlikely to generate additional resources per se, it offers the potential to deliver better outcomes and improve people's experiences of services. The CQC's local system reviews, focused on care and support for those over 65, is also an attempt to identify opportunities for improving the way in which health and social care services work together in the current system.⁵¹

Innovation and best practice

There is considerable variation in performance between council areas across a wide range of indicators, including expenditure per 100,000 population, quality of care and delayed transfers, adult safeguarding and in organisational practice around assessment, commissioning and delivery of care services. While some of this variation may represent response to specific local circumstances, there is also likely to be remaining scope to identify and promote best practice and to spread innovation from one area to another. Building on activities by organisations such as the Social Care Institute for Excellence, Association for the Directors of Adult Social Services (ADASS) and the CQC, the government could seek to introduce and support a robust programme to identify and spread best practice, similar to the Vanguard initiative by NHS England. However, it is unclear how much further scope for efficiency savings exist across local authorities which have already experienced 7 years of budget reductions (see below).

Strengths and weaknesses

This section sets out the arguments for retaining but improving the current system, and those against it. Some of these reflect the user perspective, while others refer to the government's position, or the wider economic context.

Equity and fairness

It provides focused support

Through its eligibility criteria, the current system aims to focus public resources for social care on those with the greatest needs and the lowest means.⁵² This 'safety net' means that those with the lowest means are not expected to pay for their care (although in 2016, 56% of those in independent care homes were paying the full costs of their care, or making some contribution⁴¹).

However, despite an increase in the number of people needing care, currently this focus of support is diminishing. Over 400,000 fewer people received care services from the local authority in 2015/16 than in 2009/10.⁴⁵ Local authorities are responding to reduced budgets by providing care to fewer people, for example through stricter application of eligibility criteria,⁵³ and financial criteria have not been uprated since 2010. The decline in the number of people receiving publicly funded care seems set to continue; directors of adult social services are expecting service reductions to account for 19.5% of required savings in 2017/18.¹⁵

In addition, those who do self-fund are likely to be paying more for their care than those who are funded by their local council. The Competition and Markets Authority found that average local authority fees are below the full cost of providing care and, to compensate, self-funders are charged 41% more by care homes. In practice this means that there is a 'hidden

subsidy', and those who pay for their own care are helping to meet the costs of those who are funded by the local authority.¹⁷

It is within the government's power to revise these eligibility criteria if it wants to bring more people into receipt of publicly funded care within the current system. However, given the downward trend in those receiving care, it is likely that making small changes in the existing framework will not fully address these issues.

It could be argued that by maintaining relatively tight control of overall budgets – and particularly those relating to care for older people – the current system avoids increasing taxes which are borne by the relatively less well-off working-age population, for the benefit of the increasingly affluent older generation. However, many would argue that the primary result of this approach is a system which is under-funded, with the number of old people receiving publicly funded care having declined.

The system does not protect people from very high care costs

Within the current system, some people are exposed to extremely high care costs. In 2011 the Dilnot Commission estimated that approximately one in 10 people at the age of 65 face the prospect of care costs of more than £100,000 over their lifetime.⁴⁶ It argued that – in the absence of pre-funded insurance products – there is no way for the individual to protect themselves against the risk of these costs. This differs from other areas associated with high levels of risk, where the individual is able to insure themselves, or is covered by a publicly funded social insurance system.⁴⁶ Making a small increase to the means test threshold would lead to some reduction in the amount some people were expected to pay (ie they would be able to retain a slightly larger share of their assets), but would not make a significant difference to those facing extremely high care costs.

Not everyone is receiving the care they need

As above, the number of older people receiving local authority funding has fallen in recent years. While some of this may reflect efforts to reduce need and promote independent living, it seems to be at odds with increasing numbers of people with more complex needs.¹⁴

In addition, research carried out for Age UK suggests that there are over a million people over 65 living with needs which are unmet, an increase of 26% compared with 2010⁴⁸ (though it is not clear how many of these people would be considered as eligible for social care, were they subject to a local authority assessment).

There is local flexibility and variation in delivery

Within the current system, local authorities have flexibility in certain areas relating to social care. There is a national minimum threshold for eligibility, which councils must use when assessing people's needs (see 'Eligibility criteria' in the section, *The current system for funding social care*), but the amount spent on care, and the type and means of support provided, are determined locally. In practice there is a trade-off between giving local authorities the flexibility to respond to local circumstances, and providing some form of consistency in the quality and level of services in different areas.

Local flexibility offers local authorities scope to better manage demand and reduce costs by, for example, more closely managing the number of residents who are placed in residential care.⁵⁴ Variation in delivery may also allow innovation and quality improvement which can be spread more widely.

However, because local authorities have discretion over spending, there is significant variation in the amount spent on social care per adult in different parts of the country. The Institute for Fiscal Studies found that in 2015/16, spending in less than a tenth of council areas was less than about £325 per adult resident, while in another tenth it was more than about £445 per adult resident. There is also a wide variation in the amount raised from care recipients through fees and charges, ranging from less than £35 per adult resident to £95 or more.⁴⁴ As set out below, mechanisms for local authorities to raise additional revenue by increasing council tax are likely to increase this variation, with councils in deprived areas being able to generate less income than those in wealthier ones.

While variations in spending are not in themselves necessarily problematic, and the relationship between expenditure, access and quality is not fully understood, there are differences in performance which give cause for concern. For example, people living in deprived areas are less likely to have their care needs met: one in three men aged 65 and over in the most deprived areas have an unmet need compared with 15% in the least deprived areas.⁵⁵ There are also wide, unexplained variations in the quality of care homes between local authorities and in the rates of delayed transfers of care between acute hospitals and local authority social care services.¹¹

Economic efficiency and value for money

By restricting government support to those with the highest needs and lowest means, the current system requires much less government funding than some of the other options discussed in this paper. In the case of those who have significant housing or pension wealth, the current system deflects costs from the state towards the individual and their families. To those concerned with the burden of taxation or deficit reduction, this is a clear benefit.

However, there is a question as to whether restricting spend on social care results in costs elsewhere, in particular in more expensive health services such as accident and emergency. One consequence of insufficient and short funding is that spending on prevention – an area seen nationally and locally as a strategic priority for local government – was in fact expected to fall in 2017/18.¹⁵ The National Audit Office has also raised a concern that reducing local authority spending may be creating 'unsustainable pressure' on informal carers and acute health services.⁵⁶

Sustainability and resilience

It is resilient to changes in funding

The current system has proved resilient to growing budgets, but also to shrinking ones, a test many systems may have struggled with (although the number of people receiving publicly funded care has fallen).

The current system has 'levers' that local or national government can pull to adjust the level of demand for funding. These include the lower and upper thresholds which, in recent years, have not been uprated in line with inflation and so have led to more people being 'outside'

the system. Similarly, the government could reverse this policy and so provide support to more people – although without additional funding this would simply transfer additional demands on local authorities.

It has also been argued by councils that the resilience of the social care system has reached its limits, and that the scope of making savings reduces over time. Councils have made significant savings in recent years; ADASS estimates that total cumulative savings in adult social care since 2010 will amount to over £6bn by the end of 2017/18.⁵⁷ In its annual budget survey, directors estimated that efficiency savings would make up more than half of all savings for 2017/18. Only 31% of respondents were fully confident that planned savings would be met in 2017/18 and only 7% were fully confident they would be met in 2019/20.¹⁵ Councils also face additional spending pressures from issues such as the national minimum wage. As such, there must be doubt as to whether continuing to seek efficiencies and spreading best practice – albeit a potentially important intervention in its own right – will make significant inroads in the estimated £2.5bn spending gap facing councils by 2019/20,⁴⁵ or achieve sustainability over the longer term.

National funding has been insufficient and too short term

It is also argued that the level of spending on social care currently, and the recent efforts to address a shortfall in the short term, are not sustainable. The adult social care support grant for 2017/18 has been criticised for being a redistribution of existing funding, and insufficient for meeting the funding gap.⁵³ In addition, government has responded with a number of short-term actions that do not fully address the funding gap and are unlikely to be sustainable.

The first main mechanism – the social care precept – is unlikely to raise enough to address the fundamental shortfall in funding councils are experiencing – even if it were to raise the maximum possible. Moreover, the variation in the level raised between local authorities, and council's reluctance to apply it, means that many consider it unsustainable as a funding source.^{53,36}

The second main mechanism – the BCF – has been criticised for being overly bureaucratic and, more recently, has been the subject of a bitter dispute between local government and the NHS over the objectives to which the additional money should be put, with the NHS locally and nationally wishing for a greater proportion to be spent specifically on reducing delayed transfer of care from hospitals.⁵⁸

It is also worth noting that these measures have added further layers of complexity to the social care funding system, and contributed to the lack of transparency in how spending decisions are made.

Local authorities are unable to raise income to supplement national funding

Though the social care precept allows for some income raising, councils' other options for supplementing their expenditure on social care are limited, especially as they already raise £2.7bn in client contributions (from a declining service user base). Councils do in theory have an option of increasing council tax by an unlimited amount to fund social care, but none has taken up the option of holding the local referendum that would be required to do so. This may be because the level raised through this mechanism depends on how much of the

council's overall social care spending is funded through council tax; if council tax covers only a small percentage of the overall budget, it would need to be increased significantly to make a big difference to the council's overall social care budget. Similarly, the amount raised in each area would be determined by the existing tax base, rather than by the level of need.

Over the longer term, the government's intention is to make local authorities fully reliant on revenue raised locally through council tax and the retention of business rates, in place of a central grant. This may have some advantages, in particular giving local areas more flexibility, but the dependence on the level of property wealth and economic activity (particularly growth in economic activity) is likely to disadvantage the areas where these are weaker.¹⁴ This is also likely to increase variation between different areas.

Uncertainty of funding leads to uncertainty of service provision and market instability

Issues around sustainability of funding impact on sustainability of services, which are overwhelmingly contracted out to the private and voluntary sectors. Since 2010, local authorities have in part responded to falling social care budgets by outsourcing provision and reducing the fees they pay providers for care services. Fee levels fell by an average 6.2% from 2011 and, even though average fees are now increasing, this has led to widespread market instability. Combined with other issues, such as acute workforce shortages, there is a high risk of large-scale provider failures.¹⁴

Within the current system providers are able to cross subsidise local authority funded users with income from self payers, which arguably provides some stability. However, despite this, many councils have reported home care providers in particular handing back council contracts. The Competition and Markets Authority found that profitability of care homes was related to their source of funding, with some of those focusing on local authority funded residents struggling to generate even operating profits.

Ease of use/clarity

The system is difficult for people to understand

The current system, and the operation of the means test in particular (with an upper and lower threshold, and different rules for home and residential care) is complex. As a result, many people do not understand the system and are surprised when they are required to contribute to the cost of their care. A survey carried out in 2010 found that only 5% of people considered the social care system to be easy to navigate.⁵⁹

Indeed, poor understanding of the current system may explain some of the reaction to the Conservative's manifesto pledge to introduce a £100,000 threshold – it is possible many understood this to be the *introduction* of a means test, rather than a far more generous threshold for the existing one.

The Dilnot Commission argued that the complexity of the system is part of the reason that people do not plan for their care. It also highlighted the limited availability of information and advice on social care, and argued that this is often of poor quality.⁴⁶

Complexity may be a barrier to reform

This complexity of the current social care system may also in part explain its longevity. Rules around eligibility are sufficiently opaque and there is sufficient subjectivity in assessment that councils have been able to essentially ration services and remain within their budgets while still apparently adhering to national eligibility criteria.

In addition, the public's limited understanding of the system, and the misunderstanding around the high costs people may face when they need social care (many assume it works with the same relative generosity as the NHS), can make reform difficult unless extensive preparation work with the public has been undertaken and, of course, that the funding proposals themselves mesh well with the public's underlying values.

The social care system is not integrated with other care and support

Users of social care services are often in receipt of other forms of support, for example the state pension, or disability and housing benefits for those of working age. However, for the most part this support is not properly coordinated, and people are subject to multiple forms of assessment.⁴⁶ A review of the attendance allowance also highlighted the limited integration between this benefit and the social care system.⁶⁰

There is a lack of alignment between health and social care

While there is scope to greater integrate health and care within the current system, there are also substantial differences which limit the potential for that integration, increase administration costs and can create confusion and a sense of unfairness among services users. Making incremental improvements to the current system does not address this fundamental lack of alignment between the health and care systems.

Most fundamentally, social care is subject to a needs test and a means test, while health care is largely comprehensive and free at the point of use. Campaigners point out that because some long-term conditions such as dementia are largely untreatable medically, the great proportion of their care costs fall on the social care system. Many people are therefore required to pay the costs of their care themselves, which has been dubbed a 'dementia tax'.

The fine distinction between health and care costs is highlighted 'at the boundary' by NHS CHC – nursing support for those with 'incurable' conditions – which is provided by the NHS at no cost to the individual (see Box 2 in *The current system for funding social care*). There have been many court battles fought over whether an individual should qualify for free CHC, or means-tested social care.⁵

The Barker Commission on the future of health and social care also highlighted the lack of alignment in the approaches to funding health and social care; while the NHS is funded through a national, ring-fenced budget, there is no national allocation for social care services, and it instead relies on multiple sources of funding, including user charges.⁵

In addition to these differences in eligibility and funding, there are a wide range of differences in the way the two systems operate, including in terms of governance, accountability and regulation, and in professional cultures and ways of working. Evidence suggests that overcoming these fundamental differences is likely to take time; indeed, a

recent review by the National Audit Office highlighted that nearly 2 decades of initiatives to join up health and social care has not led to system-wide integration.²⁴

Implications for working-age people

A more generous means test would benefit some of those of working age who are receiving social care. However, given that these recipients tend to have lower incomes and assets than older people (and therefore are more likely to receive public support on the basis of means), revisions to the needs tests are likely to have a more significant impact on the numbers receiving publicly funded care. As is the case with older people, however, these changes would need to be supported by additional public funding and, as set out above, the approaches which have been taken to ease pressure on social care funding within the current system to date have been insufficient and too short term.

Considerations around implementation

Compared with the implementation of a new model for funding social care, which would be likely to involve significant time and resource, continuing with the current system involves minimal disruption, and comes without any transition costs. The relative ease with which governments can find a temporary funding solution, rather than grasp the potentially thorny, complicated and possibly unpopular (given the public's low perception of the current social care system) reform agenda perhaps explains the history of social care funding in England over recent decades.

However, as noted in previous sections, although the current system has been in place for many years, there continue to be challenges around its implementation in practice – for example, its complexity means it is difficult for people to understand.

Conclusion

There is scope for making a number of changes within the current model for funding social care, aimed at addressing some of the challenges described. Not only would this avoid the challenges of implementing a new model, it would be consistent with the approach taken by successive governments over many years. As such, this approach is arguably a pragmatic option, which recognises the longstanding difficulty in achieving radical reform.

However, while this approach would bring about some small improvements, it fails to address any of the fundamental problems with the current system. In particular, in the face of growing demand, small changes in the means test are unlikely to make a significant difference to the trend of growing numbers of people with unmet care needs, and the rise in privately funded care. As previous attempts have shown, introducing new mechanisms to 'top up' spending on social care is unlikely to place the system on a sustainable financial footing, and consequently there is a risk that public funding will continue to become smaller and smaller as a proportion of overall care funding.

Table 3: Summary of the improving the current system approach

Attributes	Strengths	Weaknesses
Equity/fairness	<ul style="list-style-type: none"> • Limited resources are focused on those with the lowest means, and those with the highest needs • Avoids additional tax burdens on the working-age population 	<ul style="list-style-type: none"> • Does not protect people from very high care costs • Evidence of rising unmet needs and reductions in people receiving publicly funded care • Entitlement for health and social care is not aligned and the system does not provide equal treatment for equal needs (highlighted at the boundary – CHC) • Significant variation in provision • The low means test means that those with relatively modest means are expected to pay for their care
Economic efficiency/VFM	<ul style="list-style-type: none"> • Low unit costs 	<ul style="list-style-type: none"> • Separation between health and social care leads to ‘cost shunting’ between the two • Limits allocative efficiency; focus on highest levels of need leads to falling spend on prevention and fuels demand for relatively costly long-term care • The high levels of care provided by unpaid carers impacts on the wider economy
Sustainability and resilience	<ul style="list-style-type: none"> • Local authorities have some flexibility over spend • Arguably it has proved robust to fluctuations in local authority funding 	<ul style="list-style-type: none"> • System requires ‘topping up’, and recent measures are not sustainable/unpredictable, eg precept • Uncertainty of funding has led to problems with market sustainability

Attributes	Strengths	Weaknesses
Acceptability and accountability	<ul style="list-style-type: none"> Local authorities are accountable for local services – although in practice this is undermined by the complexity of the system The Care Act was widely supported 	<ul style="list-style-type: none"> Public understanding is poor
Clarity/ease of use		<ul style="list-style-type: none"> System is complicated for people to understand Not well integrated with other care and support
Implementation	<ul style="list-style-type: none"> No transition phase required – no disruption from reform whether political or economic 	

The 2017 Conservative Party proposals

Box 10: Key features of this approach

- The Conservative Party Manifesto proposed **two key changes to the means test** for social care:
 - the existing ‘upper’ and ‘lower’ thresholds would be replaced with a single threshold, set at £100,000, much higher than the current upper threshold
 - savings and property assets would be included in the means test for both residential and domiciliary care, rather than for residential care only as is the case currently.
- Subsequently, **a cap on the lifetime costs of care** was added to the package, which would mean that no one would need to pay above a certain level. The level of the cap has not been specified, although some commentators have suggested this may be £100,000.
- These proposals relate to the nature/scope of the government’s offer on social care; they are **not a means of generating additional funding** (although the Conservative Party Manifesto proposed means testing the winter fuel allowance and directing the proceeds to social care).

During the 2017 general election, the Conservative Party set out a radical change to the publicly funded offer on social care. This combined a significant increase in the assets people were allowed to keep before contributing to their care costs with the introduction of a cap on lifetime costs of care – although this was not included originally in their manifesto. The funding required for this change was intended to come, at least in part, from means testing winter fuel payments for older people.

What is it?

The means test

The Conservative Party Manifesto proposed two major changes to the approach to means testing under the current system (as set out in the section, *The current system for funding social care*):

- It raised the means test to a single floor of £100,000, thereby abolishing tariff income and ensuring that users always retained at least £100,000 in assets.
- The value of a user’s own home was included, as now, within the means test for those in residential care but was also to be included in the estimate of assets for people receiving care in their own home.

Important details of this new means test would need to be set out – for example, how to treat the value of a home owned by a couple, when one of them needs care.⁶¹

The approach set out by the Conservative Party is different from that set out in the Care Act, which legislated those elements of the Dilnot Commission’s work that the government accepted. The act identified an upper means test of £118,000, and retained a lower threshold at £17,000 (all in 2016/17 prices). The Care Act also retained tariff income, which

would require people with assets worth between £17,000 and £118,000 to make some contribution to their care costs. If the approach to tariff income remained as now, this would have left people making substantial contributions towards the cost of their residential care. For example, for someone with assets of £100,000, this would have meant an annual contribution of over £17,000 a year. By contrast, under the Conservative Party proposals that same person would need to make no contribution at all.

Extended deferred payment system

This system would mean that for people unable to contribute to their care costs without releasing funds from their housing assets, the local authority would pay in the short term and recoup the costs from the property after their death (see Box 6).

The inclusion of the value of people's homes in the means test for home care as well as residential care means that this system would need to be expanded to ensure people did not need to sell their own homes during their lifetimes to pay for own domiciliary care.

A cap on lifetime costs of care

A cap would outline a maximum contribution that anyone would need to make to their care costs throughout their lifetime. Those not eligible for means-tested support (see above) would be expected to meet the costs of their care up to the level of the cap.

A cap on lifetime care costs was first recommended by the Dilnot Commission in 2011. The commission proposed a cap of between £25,000 and £50,000, beyond which the state would pay.⁴⁶ The Care Act intended to establish a cap of £72,000 (in 2016/17 prices), while the Conservative Party's proposals did not specify the level at which this would be set.

How the cap operated in practice would depend on several factors, including:

- **The level at which the cap was set.** The Dilnot Commission argued that the cap needed to be set low enough to ensure that those on lower incomes were provided with adequate protection, but high enough to ensure that the system was sustainable. On this basis, the commission argued for a cap between £25,000 and £50,000, using £35,000 as an example.⁴⁶ The commission also recommended that the cap be adjusted over time, in line with inflation and changes in income. However, in the Care Act 2014, which enshrined elements of the Dilnot Commission's recommendations, the cap was raised to £72,000. It was subsequently postponed to 2020 and has now been abandoned.
- Whether a '**general living costs contribution**' was required, as proposed by the Dilnot Commission. This would require those in residential care to pay a contribution to their general living costs – food, heating and accommodation – on an annual basis, even after reaching the cap on care costs (the cap is on lifetime costs). The commission argued that this contribution should be set at a level which is affordable and representative of these costs, and that it would need to balance this contribution against the level of the cap.⁴⁶
- Whether or not eligibility for social care was nationally set.

Understanding the offer

Income contributions

Much of the discussion around paying for social care has revolved around the need for people to use up their own assets to pay for care, particularly where they are forced to sell their own homes. However, it is important to understand that it is not only their assets or wealth that is at threat from the potentially high costs of social care; individuals' incomes are also taken into account when determining the contribution the public purse will make towards costs (see 'The current system for funding social care' above). This may mean, for example, that older people receiving pensions are required to use these to pay for care costs. In many of the analyses (including that presented here) of social care funding, the assessment is simplified by assuming the recipient's income is just sufficient to meet their living costs at around £11,000 per annum (whether in their own homes or as a contribution to the overall costs of residential care). However, it needs to be remembered that this is a simplification and many will have higher incomes and be expected to contribute towards their care costs accordingly, irrespective of the assets they may hold.

Top-ups

Many people currently pay their own care costs, and there is evidence that this number is growing.⁴¹ However, this is not used when calculating how much someone has paid towards the cap. Instead, the contribution towards the cap is based on the assessment of need undertaken by the local authority and their estimate of the costs this would incur. While many may choose (or feel obliged) to spend more than this sum on their own care – whether towards care in their own homes, or by choosing a more expensive residential home than the local authority would pay for – this top-up or additional payment would be disregarded when calculating how much an individual has paid towards the cap.

Administrative costs

It is likely that many people organise their own care without reference to the local authority, especially for domiciliary care (and that the proportion which do this varies in different parts of the country). This is understandable when many may not be eligible for any financial support. However, under a system that sets a maximum cap above which people do not pay for their social care, there is a strong incentive to get a local authority assessment to 'start the meter' running, recognising the costs facing individuals even if the local authority is not yet contributing towards meeting them. This is likely to create substantial extra work for local authorities, both for first assessments and reassessments (where people's needs change). Administrative costs would partly depend on the approach taken to metering; the Dilnot Commission rejected the option of metering individual spend, primarily on the grounds that the administrative burden would be too great.⁵²

Under the model proposed in the Care Act, these administration costs were estimated to reach an upper limit of £2.1bn (net present value).⁶² The likely increase in deferred payments will also add to the administrative costs facing local authorities.

Impact on individuals

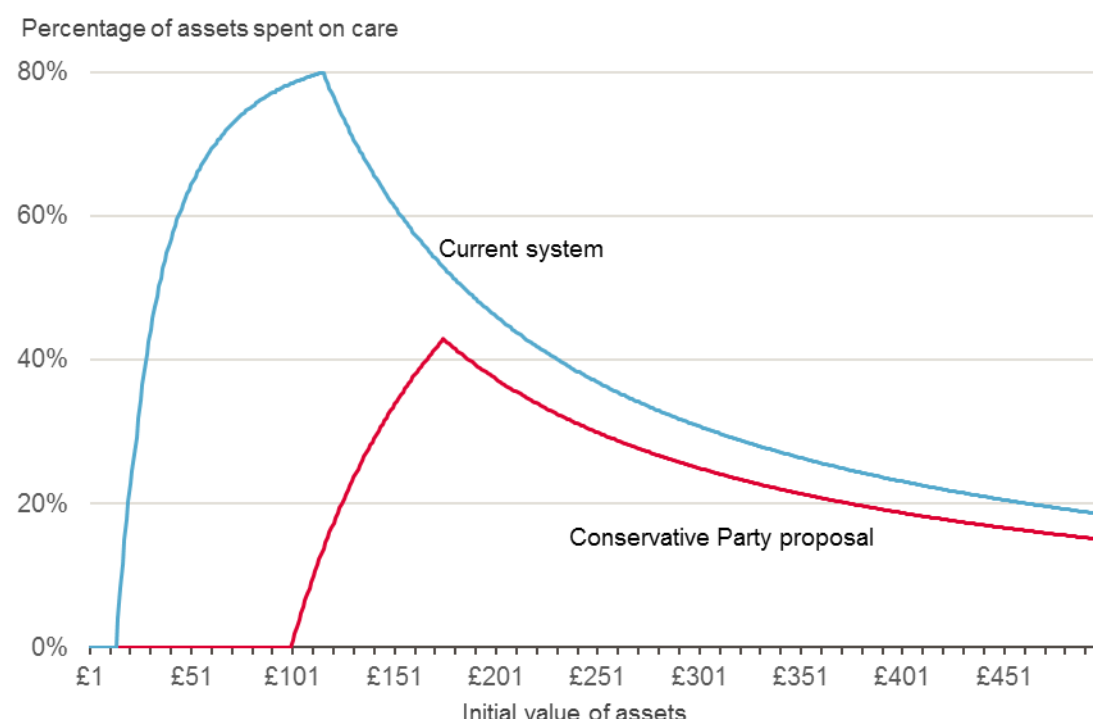
Comparing the Conservative Party's proposals to the current system is complex, not least because the current system is itself inherently complex and difficult to understand. Table 4 sets out the main groups of winners and losers.

Table 4: Summary of winners and losers under the 2017 Conservative Party proposals, assumes 5 years of care, a Dilnot cap of £75,000 and recipient's income is just equal to general living costs

Total assets	Residential care	Domiciliary care: assuming all assets are housing	Domiciliary care: assuming assets are non-housing
Less than £14,250	No impact: already below the means test	No impact: already below the means test	No impact: already below the means test
Between £14,250 and £23,250	Winner: no longer makes tariff income contribution and becomes fully funded	No impact: assets remain below the means test	Winner: no longer makes tariff income contribution and becomes fully funded
Between £23,250 and £100,000	Winner: below new means test and becomes fully funded	No impact: assets remain below the means test	Winner: below new means test and becomes fully funded
£100,000 – £175,000	Winner: higher means test provides higher protection	Loser: pays 100% of costs until assets fall to £100,000	Winner: higher means test provides higher protection
More than £175,000	Winner: higher means test and cap combine to provide higher protection	Loser: pays 100% of costs until hits the cap	Winner: higher means test and cap combine to provide higher protection

The pattern of winners and losers depends closely on the type and cost of care received, and the location in which it is purchased. Figure 1 illustrates the potential impact on someone who enters residential care for 5 years, with a cap of £75,000 and a single means test of £100,000 (in practice 5 years is a long time for someone to spend in a care home; this figure has been chosen to demonstrate how the cap could work in practice – the cost of care for a period of less than 5 years may never reach the level of the cap). The proposed system is more generous than the current one, whatever the initial level of assets owned by the individual, although the gains are strongly skewed to those with assets between £14,250 and £100,000, then eroded until the cap bites once they have spent £75,000.

Figure 1: Percentage of assets lost under the current system of funding for social care and the Conservative Party proposals: £150,000 costs of residential care over 5 years, with living costs met from income of £11,500. Cap on care costs of £75,000.



The Conservative Party did not state the value of the cap and some commentators have referred instead to £100,000 as the possible value. The Dilnot Commission originally recommended a cap set at £35,000. The Care Act 2014 raised this to £72,000 (or £61,000 in 2010 prices).⁴ Raising it again to £100,000 under the wider assumptions laid out here would make it relevant to only a small number of very high cost users. This is because if people are assumed to use their own incomes to cover general living costs when in residential care (or in their own homes), then they would need to spend over £150,000 including general living costs to reach the cap. Based on analysis in the Impact Assessment for the Care Act 2014⁶² this would only apply to around 1 in 20 people aged over 65.

As in the previous option, the Conservative Party's proposals included the extension of the Deferred Payment Scheme, suggesting that this would apply in all the examples above. In practice, however, this would depend on the way in which the DPA scheme operated.

Examples

In all the worked examples presented overleaf, it is assumed that the people described have just sufficient income to pay for their general living costs (at around £11,500 a year).

Example 1: Under the new means test

Current system
James owns his own flat which is worth £80,000. After suffering a stroke, he goes into residential care for the last 3 years of his life. He has to sell his home to pay for his care. After 3 years, James has spent over £55,000 from the proceeds from the sale of his flat and is left with less than £25,000. This means he has spent nearly 70% of his assets to fund his care.
Under the proposals
The value of James' assets (his flat) is below the means test and he doesn't have to contribute beyond covering his general living costs. The full value of his flat is retained.

Example 3: Helped by the cap

Current system
Patricia owns her own house, worth £250,000. After becoming increasingly frail, she goes into residential care for the last 5 years of her life. She has to sell her home to pay for her care. After 5 years, she has spent over £90,000 from the proceeds of the sale of her house and retains just under 65% of her assets.
Under the proposals
Patricia spends £75,000, reaching the cap on spending. After this point she no longer has to meet the costs of her care. She retains £175,000 from the proceeds of the sale of her house, keeping 70% of its value.

Example 2: Helped by the means test

Current system
Mary owns her own house, worth £150,000. After a bad fall, she goes into residential care for 5 years. She has to sell her home to pay for her care. She spends £90,000 on her care. At the end of the 5 years, Mary has less than £60,000 of the proceeds from the sale of her house. She has spent over 60% of her assets.
Under the proposals
Mary spends £50,000 from the proceeds of the sale of her house before she reaches the £100,000 means test. From this point she no longer has to pay for her care costs. She retains £100,000 from the sale of her house, keeping two-thirds of her assets.

Example 4: Care in your own home – losing from the change

Current system
Mark's arthritis has made it difficult for him to look after himself without help and he receives care in his own home for 4 years. He owns his own house worth £150,000 but only has financial assets of £10,000. This means he's below the means test for domiciliary care and doesn't need to contribute towards his care costs, which are £5,000 a year.
Under the proposals
The value of Mark's house is now included in the means test and his total assets of £160,000 mean he is not eligible for any financial support. He's helped by a deferred payment scheme so he doesn't need to sell his own home to pay for his care costs once his savings have been spent. After 4 years, he's spent £20,000 from his assets. He retains around 88% of their value.

Note: The cost of care met from assets is assumed to amount to £18,500 per year, with users' income sufficient to meet other living costs.

How many winners and losers are there?

It is important to understand not only who would win or lose under the Conservative Party proposals (ie in terms of care needs and means), but how many people are affected.

Table 5 presents estimates of the number of people falling into key categories of winners and losers. This is based on the number of people eligible to pay for their social care (not how many people actually paid for social care). The changes in domiciliary care are relatively complex as these combine:

- Some who win from the changes, including those with financial assets of over £23,250 which means they would be expected to contribute from their assets towards the costs of their care under the current system but have less than £100,000 in total assets, which means they would be protected by the new means test under the Conservative Manifesto.
- Some who lose from the changes, as they have low financial assets (so would not pay under the current system) but have over £100,000 total assets, above the means test and so are liable to pay for their care.

House-ownership is high among the over 65s, which means many older people have relatively high total assets (mostly locked up in the value of their home); indeed 78% of the 65–74 age group are owner-occupiers.⁶³

In the case of those receiving domiciliary care, it is the cash-poor but housing-rich (ie those with property worth more than £100,000) who will lose from the changes as the value of their home would no longer be ignored in the means test. Given the differences in house prices across the country, in practice the consequences of this change will differ in different parts of the country.

Table 5: Key winners and losers among service users, comparing the current system and the Conservative Party proposals

Group	Percentage of total population aged over 65
Big winners: if going into residential care with assets between £23,250 and £100,000	19%
Moderate winners: if going into residential care with assets between £100,000 and £175,000	23%
Smaller winners: potential winner if going into residential care with assets over £175,000	44%
Losers: net increase on those paying for domiciliary care (not including tariff income)	25%

Note: those going into residential care with assets between £14,250 and £23,250 will also gain as they would no longer be subject to tariff income. Including tariff income in the assessment of net winners and losers in the changes to domiciliary care will reduce the number of losers.

Source: Analysis by The King's Fund and the Health Foundation

Strengths and weaknesses

Equity/fairness

It may protect people from very high care costs

In principle, introducing a cap on care costs can help protect people from very high costs of care; risks are partially pooled, such that the costs of those with very high care needs are distributed across the population. This means that resources are targeted at those with the highest needs.⁴⁶

In practice, however, the extent to which people are protected from high care costs depends on the level at which the cap is set. The original recommendation from the Dilnot Commission was for a cap of £35,000⁴⁶. The analysis shown here relates to a cap of £75,000, close to that proposed in the Care Act. This already will directly impact relatively few people, though as it reduces the risk of catastrophic costs, it may have an impact beyond those directly benefitting financially. At most 1 in 20 might benefit financially if the cap was raised again to £100,000. (The Dilnot Commission estimated that more people – 1 in 10 – would face costs of over £100,000. However, the requirement under this system for those in care homes to contribute to their living costs – which would not count towards the cap – means the number whose care costs reached £100,000 would be greater than the number who reached a cap set at £100,000.)

Moreover, it is argued that in practice the individual may incur costs beyond the cap. Because the cap would only apply to 'eligible' needs, ie those deemed necessary by local authorities, the proportion of people receiving support would depend on the criteria used. The Care Act 2014 introduced a national minimum eligibility threshold, intended to be similar to the level of 'substantial' need under the previous fair access to care services criteria

A second reason the individual might incur costs beyond the cap is because costs would be determined on the basis of local authorities' costs, which tend to be lower than what many 'self-funders' pay.⁵ This different in rates also means that in practice individuals may want/need to top up local authority payments once they have reached the cap in order to remain in the accommodation they had been self-funding.

Arguably changes to the means test represent a 'fairer' approach to housing assets.

Firstly, introducing a floor of £100,000 would mean that many more people would receive state support for residential care than do currently (given the floor is currently £14,250). People would not need to spend nearly all of their housing assets to qualify for state support.⁴⁶ The greatest gains would come to those with assets between the current upper means test of £23,250 and below £100,000 and around a fifth of the population aged over 65 fall into this group. The gains – in terms of the assets they could retain – are greatest to this group. However, it is important to note that there is considerable variation in housing prices across the UK, which means the consequences of this change will differ in different areas.

Secondly, while the inclusion of the home in the means test for care at home will result in more people paying for this care, arguably this is a more progressive approach as those with high levels of assets will be expected to contribute.

The combined impact of a new means test and cap is complex

If it were not for the inclusion of the value of people's homes in the means test for domiciliary care, there would be no net losers under the Conservative proposal. Its implications for equity are relatively complex but include:

- no change to those with fewest assets of all
- relatively big gains to those with low to moderate assets, ie below £100,000
- smaller gains to those with greater assets and indeed, relatively few to the most well off (as they benefit only from the cap)
- losses – probably in most cases relatively modest (as domiciliary care is much less expensive than residential care) – to cash-poor homeowners, whose homes are worth more than £100,000. This is a relatively large group because homeownership is so common in the over-65s.

Proposal do not address lack of alignment between health and social care

Linked to the above – even with the introduction of a cap and a floor, the individual would still be liable for relatively high costs – which would be ‘unthinkable’ if applied to health care.⁵ As this combines a floor and a cap and extends the property-based means test, this may increase awareness of how different/separate this system is from the NHS.

Sustainability/resilience

The Dilnot Commission argued that having a system made up of different elements – such as the cap, and a living cost contribution – ensured flexibility/adaptability, as the government would be able to make small changes over time without undermining the whole model. As this model shares these features it again provides multiple levers to subsequent governments looking to fine tune the offer on social care. However, this may also make it vulnerable to cost-cutting, as it provides many levers that will increase costs on recipients too. For example, as the means test, general living costs and cap are all determined in cash terms, simply refusing to uprate by inflation will have a considerable impact.

Ease of use/clarity

An approach involving a cap on costs provides much greater transparency over the way in which costs are shared between the individual and the state⁶⁴ and a single means test would be much simpler than the approach taken under the current system. As such, elements of this approach would be relatively straightforward to explain to the public. However, operation of this system in practice (for example, ‘metering’ of costs to track when these reach the cap) is likely to be significantly more difficult for users to understand, and the system would continue to be significantly more complex (and less easy to explain) than the NHS.

Moreover, the operational implications of a means test and cap along with a greatly extended deferred payment system may be challenging. The issues to resolve include:

- Important details around the means test, such as how would the assets (home and savings) belonging to a couple be treated, if one of them needed care?⁶¹
- The number of assessments would need to increase, and the number of DPAs would have to rise. The risk of conflict/dispute is likely to increase as it becomes important how local authorities determine eligibility and costs even if they are not paying (as these

contribute towards the cap). Any confusion/dispute is likely to have knock-on consequences for the NHS as hospital discharges are delayed.

- Local authorities will need to put 'metering' systems in place to track the spending of self-funders up to the level of the cap. This will be complicated by the fact that the point at which an individual is considered to have reached the cap will be calculated on the basis of the local authority cost of care, not on the basis of what they have spent in practice (which may be much more).
- Given the discrepancy between self-funder and local authority rates, it is likely that when someone reaches the cap (or floor) and the government begins paying for their care, they will need to move to less expensive accommodation, or choose to top up government payments with their remaining assets to remain where they are.
- Local authorities may need to take out loans to manage the increased number of deferred payments given the reduction in their reserves.

Economic efficiency and value for money

System may impact on incentives for people to remain in their homes

The current rules on the means test do create some incentives for recipients to choose domiciliary care over residential care, because housing assets are excluded from the means test for domiciliary care, which is set locally by councils. In example 4, Mark does not need to pay towards his domiciliary care as the value of his house is excluded from the means test. If he were to enter a residential home, his house becomes part of the means test and he must pay for his care. For people who are relatively well off in housing assets but relatively poor in financial assets, they get domiciliary care for free but must pay for residential care.

Under the Conservative's proposals this difference in treatment of housing assets was to be removed. Mark would pay for his care whether he was in domiciliary care (which may require a deferred payment scheme) or residential care. The incentives to access free domiciliary care are removed for this group of the population. A similar effect is seen for those with housing assets between £23,250 and £100,000 and few financial assets: in this case, the current system provides domiciliary care for free but charges for residential care. Under the Conservative's proposals, both would be free, removing the relative advantages of domiciliary care. This may be seen by many as unhelpful, given that current health and care policy is aimed at supporting people to live independently, and/or receive care in their own homes, avoiding hospital admissions and long-term care as far as possible.

However, whether these changes to incentives would be sufficient to change behaviour is unclear. Of course, whether the incentives towards domiciliary care (for those who experience them), is economically efficient or fair is also debatable.

There is a question about the alternative uses of funding

There is also a question around the opportunity cost of implementing a cap on costs along the lines of that described above.

It could be argued that this would mean spending public money to protect people's private assets, instead of targeting this money at those with the lowest means. In 2015, implementation of the cap set out in the Care Act was postponed, in part because local

authorities argued that the priority was to focus funding on maintaining mainstream social care services.⁶⁵ However, this argument could equally be applied to many other areas of public spending – including in the context of wealthy individuals receiving very high cost health services for free through the NHS.

Implications for working-age people

As working age recipients of social care tend to have lower incomes and assets than older people, it is more likely that they would fall within the £100,000 means-test. For those entering adulthood with high needs it is also likely that they would rapidly hit the cap. As such, this group is likely to benefit from these changes, as long as the funding for those reliant on the public sector is set at the necessary level. Alternatively, as per the recommendations of the Dilnot Commission (and the terms set out in the Care Act), those who entered adulthood with eligible care needs could be treated as having effectively met the cap, and entitled to state funded care.⁴⁶

Considerations for implementation

Ease of implementation

Implementation of the Conservative Party's proposals would be aided by the fact that some of the principles set out by the Dilnot Commission, such as a cap on costs, are already provided for in legislation through the Care Act, and some initial preparatory work was undertaken.

At a local level, inclusion of housing assets in the means test for both home care and residential care would be reliant on DPAs. However, we know that this is not working on a consistent basis in the current system; many local authorities do not provide this scheme, despite a legal mandate.

Communicating change

Communicating change to the public is likely to be difficult given poor understanding of the current system (although this is likely to be the case regardless of which model is adopted). This means that the proposal for a floor of £100,000 could be seen as a threat, despite this being an improvement on the current system.

There may also be a particular grievance around the cross-subsidising of local authority funded care, once this became clearer as more people get assessments.

Costs

The high costs of residential care and these proposals' relative generosity when compared with the current system will increase costs. The inclusion of a cap, and administration costs, will further add to spending.

Conclusion

Inclusion of a cap and raising of the floor (particularly if there is a single floor) is likely to mean a more generous system; however, there are real concerns around implementing and operating such a complex system. Whether this is the best use of increased spending on social care given the complex pattern of winners and losers (some of whom will make big gains), will be a value judgement, but a complex one.

Table 6: Summary of the 2017 Conservative Party proposals approach

Attributes	Strengths	Weaknesses
Equity/fairness	<ul style="list-style-type: none"> • People are protected from very high care costs – no one would pay above the cap • Greater protection for homeowners in residential care (threshold raised to £100,000) • If the £100,000 floor is a 'single floor', the system would be significantly more generous than the current one where anyone with assets over £14,250 has to make some form of contribution • Greatest protection to those with fewest assets via the enhanced floor 	<ul style="list-style-type: none"> • Individual contribution for some may still be high, depending on the value of the cap • Does not address lack of alignment between health and social care • Question as to whether the pattern of winners and losers is worth the required investment
Economic efficiency/VFM		<ul style="list-style-type: none"> • Current incentives for domiciliary care removed
Sustainability and resilience	<ul style="list-style-type: none"> • Did not argue that the range of features provided future governments with flexibility – ie could change floor and cap as required 	<ul style="list-style-type: none"> • The complexity and number of triggers (means test, cap, general living costs) may make it easy to make it less generous
Acceptability & accountability	<ul style="list-style-type: none"> • Public likely to welcome a cap on costs and higher means test 	
Clarity/ease of use	<ul style="list-style-type: none"> • Argument that having a cap would provide certainty – people will know the extent of the costs 	<ul style="list-style-type: none"> • Cap may be complex, though the single floor reduces complexity • 'Metering' spending up to the cap is complex
Implementation	<ul style="list-style-type: none"> • Existing provisions in the Care Act, for example for a cap on care costs, would ease the implementation of this system 	<ul style="list-style-type: none"> • Concern around reliance on deferred payment scheme, given current variation • Metering and a cap are new to the UK

Single budget for health and social care

Box 11: Key features of this approach

- This approach would mean bringing health and social care funding together into a joint budget at both national and local level. While this would mean a different approach to the management of social care funding, it is not a means of generating additional funding for social care.
- In practice, a joint budget is also likely to mean changes in commissioning arrangements, with a joint commissioner for health and social care services.
- However, this model does not in itself mean that health and social care service delivery would be more integrated, or that there would be more aligned approach to entitlement for health and social care.

What is it?

A single budget for health and social care could take various forms. Within the current system, many local authorities and CCGs are already operating joint health and social care budgets, including through the BCF and as part of sustainability and transformation partnerships. These arrangements typically involve pooling funding for a particular service or set of services, or for a specific population group or condition. They tend to rely on joint working between organisations, rather than a formal change in organisational responsibilities.

A different approach to a single budget would be to pool funds for health and social care formally at both local and national level. This could involve a change in commissioning responsibilities, such that a single organisation was responsible for commissioning both health and social care services locally. A change of this nature is likely to require primary legislation.

In the context of the wider debate on social care funding, this approach represents one option for the way in which social care funding is administered, but it does not of itself have any bearing on the extent of the government's offer on social care, or how this would be funded. If eligibility for NHS and social care remain unchanged, then many of the current problems with social care would remain.

Who proposed it?

The pooling of health and social care budgets has been central to the debate around integrating health and care for many years. Bringing together funding (and commissioning) for these areas is seen by many as a key enabler for more integrated service delivery. This issue has been highlighted many times in recent years, including in 2014 by the Barker Commission, which identified the difference in funding arrangements for health and social care as a key reason for the lack of alignment between the two systems, recommending that 'England moves to a single, ring-fenced budget for health and social care, with a single commissioner'.⁶⁶

The Labour Party has also called for a single health and social care budget on several occasions in recent years. During the 2017 election campaign, the Labour Party set out proposals for creating a 'National Care Service' to be established alongside the NHS, with a

requirement for single commissioning and pooled budgets.⁶⁷ Similarly, the Liberal Democrats' 2017 manifesto set out a long-term goal to integrate the NHS and social care into a single service, pool budgets by 2020 and develop integrated care organisations.⁶⁸ Both parties seek a cross-party consensus to plan mutually acceptable funding options which arise from the central idea of integrated health and social care.

Existing examples

Some steps have already been taken towards pooled budgets, although none of these have involved a formal change in commissioning responsibility.

Since the 1970s, steps have been taken to improve alignment between health and social care resources, including joint finance in the 1970s and 1980s, and new legal powers for local authorities and NHS bodies to pool budgets through the Health Act 1999 to aid integration.⁶⁹ More recently, the Better Care Fund (BCF) was announced by the government (in 2013, as the Integration Transformation Fund) to be used as a local pooled budget for integrated health and social care services. In 2016/17, £5.9bn was pooled in the BCF.⁷⁰ The Barker Commission and others argued that the BCF represents a step in the right direction towards aligning funding streams, entitlements and organisation of health and social care services, although on its own it is not a sustainable long-term solution.⁵ More recently, a review by the National Audit Office found that nationally, the BCF had not achieved principal financial or service targets in its first year (2015/16), although it has helped incentivise partnership working at a local level, and that it has not reached its potential in terms of managing demand for health services.²⁴

There are many other examples of health and social care budgets being pooled locally, in addition to BCF arrangements, with CCGs and local authorities entering into joint arrangements, often in respect of a particular population group (such as older people) or in relation to a particular condition (these are often informal arrangements, which change over time).

In the case of Greater Manchester, devolution arrangements have involved the pooling of health and social care budgets more widely. The devolution of health and social care in Manchester was announced in 2014, and consisted of an agreement between Greater Manchester Combined Authority, government, NHS England and 12 CCGs (though strictly speaking this represents delegation, rather than devolution⁷¹). Simon Stevens stated it 'charts a path to the greatest integration and devolution of care funding since the creation of the NHS in 1948'.⁷² The Greater Manchester Health and Social Care Partnership Board is overseeing devolution and has taken charge of a pooled £6bn health and social care budget with joint commissioning. Following on from this, in June 2017 a health and social care devolution deal has been made in Surrey.

Some sustainability and transformation partnerships, which bring together organisations across health, social care and other local public services, are also pooling health and care funding to support more integrated services.⁷³ As the system moves towards integrated care systems, it is likely that many more local areas will enter into joint arrangements for health and social care funding.

The Integrated Personal Commissioning programme is a different approach to bringing health and social care budgets together. This is focused at the level of the individual,

suggesting that integrated budgets can work at multiple levels. Launched in 2015, the programme builds on the experience of personal budgets in health and social care, enabling those with the most complex needs to join up funding for their health and social care services, so that the care they experience is more integrated. The programme was introduced in a number of pilot sites, but the intention is for the model to be operating in every locality by 2020.⁷⁴

Strengths and weaknesses

The primary argument in favour of a formal single health and care budget is that it would support the long-term policy ambition of improving integration between health and care services. Evidence suggests that pooled budgets are one of the most important mechanisms for joint working between these sectors.⁶⁹ Efforts to join funding at a local level are key to plans to deliver integration, and a more formal approach could represent significant progress towards aligning the two systems.

However, it is also important to recognise that a single budget would not guarantee integration of services. A recent report by the National Audit Office highlighted the failure of nearly 20 years of initiatives – beginning with the freedom given to the NHS and local authorities to pool budgets in 1999 – to bring about system-wide integration of services.²⁴ Nor would the establishment of a single budget in itself lead to changes in entitlement for social care.

Equity/fairness

Would support alignment between health and social care

The lack of alignment between the health and social care system is considered by many to be unfair. The Barker Commission highlighted the difference in approach to funding, and the difference in entitlement, as key features of this lack of alignment. At present, patients who have long-term conditions with similar needs may have vastly different care entitlements, depending on their diagnosis; patients assessed to have a primary health need are entitled to fully NHS funded care (NHS CHC – see section, *The current system for funding social care*), including social care outside of a hospital setting – whereas others are reliant on the means-tested social care system.

In recent years, cuts to social care funding have seen the two systems diverge further; between 2009/10 and 2014/15 local authority spending on social care for older people has seen a real-terms cut of 9%, and the number of people receiving publicly funded social care has fallen⁷⁵ – taking the system further away from the NHS, in which nearly all care continues to be free on the point of access. Recent financial pressures also appear to have increased the incentive on organisations to ‘shunt’ costs between one another.⁷⁶

More formal arrangements bringing together health and social care spending could lead to significant progress in this area. The Barker Commission argued that a single ring-fenced budget, with a single commissioner, would support the alignment of entitlements for health and social care services. The commission argued that this system would be fairer by providing care based on identified needs rather than ability to pay.⁵

It is important to note, however, that the divide between the health and social care systems is manifest in various ways, and there are longstanding differences between the two sectors – for example in terms of regulation, workforce and culture. Indeed, bringing the two budgets together may serve to highlight some of these differences, such as the approach to charging, and may make it challenging for existing organisations to provide direction and management appropriate for both sectors. As such, changes to funding arrangements alone are unlikely to be able to achieve alignment between the two systems.

In particular, while establishing a single budget may support integration and enable joined-up decision-making across care pathways, of itself it does not alter rules on entitlements. People would still be able to access most NHS services for free, but could be liable for (potentially very high) costs if they entered a care home and were not eligible for NHS CHC. Taking steps to align entitlements to health and social care, particularly if this meant providing more social care free at the point of use, would impact on the level of public funding required for social care.

Would support alignment between health, social care and other funding streams

The establishment of a single health and care budget might also be an opportunity to bring together some of the other funding streams which support those with care needs, such as the attendance allowance. The Barker Commission recommended that attendance allowance should be brought within a new single budget for health and social care, based around personal budgets.⁶⁶ However, as with the health and social care, it is important to stress that a change in funding arrangements may support but can by no means guarantee better integration.

There's a risk social care loses out

While pooling health and social care funding presents significant opportunities for more integrated care, it also comes with the risk that funding allocated to one part of the system is diverted towards another. This issue is frequently noted in the context of health care funding, where – when under pressure – resources are often allocated to acute and emergency care at the expense of other parts of the system, such as mental health or community services. For example, delivering parity of esteem between physical and mental health has proved difficult while funding continues to be focused on acute trusts.⁷⁷ Similarly, a recent report by the National Audit Office noted that sustainability and transformation funding that had been identified to support transformation, including the better integration of services, in practice has been used primarily to address NHS trust deficits.²⁴

Economic efficiency and value for money

The scope for making savings is often used as an argument for integrated care. The Wanless Review, for example, argued that better integration between health and social care was key to using resources effectively, in particular by helping reduce the amount of care which takes place in a (costly) acute setting.⁷⁸ More recently, a review of patient records by the Local Government Association estimated that the annual efficiency savings through better integration of health and care services could be as much as 7–10%, or £1bn a year nationally. Areas of opportunity include avoidance of hospital admissions and better discharge planning.⁷⁹ In the case of Greater Manchester, although there is a projected funding deficit on health and social care services of £2bn by 2020/21, over this timeframe

there are proposed savings of £1.5bn, mostly coming from NHS provider productivity savings and joint working.⁸⁰

Overall, however, while integration can achieve better outcomes and improve people's experiences of services, the evidence on whether integration leads to sustainable financial savings or a reduction in hospital activity is mixed.

To date the BCF has not improved economic efficiency as expected. A recent review by the National Audit Office concluded that, although it has been successful in encouraging local areas to work together, nationally the BCF did not achieve its financial targets. From the £5.3bn spent in 2015–16, planned reductions in rates of emergency admissions were not achieved, nor did the fund achieve planned savings of £511m. In fact, days lost to delayed transfers of care increased by 185,000.²⁴ However, some of these failures may have represented unrealistic expectations over both timing and impact, at a time when funding is constrained and demand for services is rising. Indeed, integration of services requires changes in patient and user pathways and is unlikely to deliver short-term savings.

Sustainability and resilience

May be more resilient

Existing examples of joint budgets operating at local level in the current system are typically based on informal arrangements, and highly dependent on effective joint working between the people involved. This can mean they are vulnerable in times of austerity: a report from the House of Commons Communities and Local Government Committee noted that in some areas NHS bodies are reluctant to truly risk share with social care organisations because of concerns about the impact of social care pressures on the NHS.⁷⁶

More formalised arrangements for a single budget, including changes in commissioning responsibilities, are likely to be more resilient to changes in local circumstances and help reduce the incentive for cost shunting between organisations.

However, it is also worth noting that, depending on the way in which it was established, a single budget for health and social care could have wider implications for local authority finance: given that funding for social care typically accounts for a large proportion of a local authority's total budget (in 2015/16, on average 38% of local authority service budgets (excluding education and public health) were allocated to adult social care⁴⁴), allocating this funding elsewhere would risk destabilising many authorities. If responsibility was transferred from local authorities to the health sector, rather than the other way around, this would potentially raise bigger questions about the future of local government. However, it could retain a range of social work responsibilities, for example those relating to safeguarding, information and advice, advocacy and community engagement.

Provides commissioner flexibility

A key advantage of any joint health and social care budget is the flexibility this would provide commissioners, enabling them to focus on joint outcomes, or outcomes for a particular group, and preventing them from becoming distracted by where costs will fall.⁶⁹ Depending on the arrangements, this should make it easier for commissioners to respond to the changing needs of their population.

Acceptability

The principle of bringing health and care budgets together is likely to be acceptable to the public, not least because many people are not clear on the nature of – or reasons for – the differences between the two systems (see below). Having a single health and care budget with aligned entitlements would certainly be more palatable to those users with long-term conditions who are not entitled to NHS CHC.

However, given recent experience on the BCF, further merging of budgets may cause apprehension among those in the social care sector that money will be ‘shunted’ from one system to the other, and/or that a change will have a negative impact on overall local government finances.

Clarity/ease of use

As set out under the ‘muddling-along’ scenario, the current system for social care is considered by many to be confusing, and there is poor awareness of how care and support services are funded. It is likely that this confusion is linked at least in part to the very different approaches taken to health and social care, with the public often assuming that social care is provided on the same terms as NHS services. Indeed, recent research found that around a quarter of the people are complacent about their potential social care costs and assume the government will provide care free of charge.⁸¹ (The public engagement work to be carried out as part of the wider project should provide further insight into the public’s views and priorities in relation to social care funding.)

However, it is important to note that establishing a joint budget is unlikely in itself to achieve these benefits: while it could help to address the separation in decision-making between the health and social care sectors and make accountability clearer, without changes in eligibility rules and funding, while there may be one commissioner, there will still be different rules over access.

Implications for working-age people

The All Party Parliamentary Group report into funding for social care for working-age people highlighted the need to remove barriers between health and social care funding for disabled people, preventing tightening eligibility thresholds and ensuring focus is on preventative care and supporting people to live independently as active citizens.³⁰ A joint health and social care budget is likely to be an attractive option for working-age people (not least as the distinction between a health and social care need for increasingly disabled people is particularly blurred). It may also be an opportunity to bring health and social care funding together with other benefits provided to people of working age, such as personal independence payments.

However, as with social care for older people, bringing health and social care budgets together in itself will not address the funding shortfall.

Considerations for implementation

As set out above, in line with the policy focus on more integrated health and social care services, many CCGs and local authorities are already operating pooled budgets. These have been established locally, on an ad hoc basis, and have been developed in line with local circumstances. This direction of travel is also evident in the development of sustainability and transformation partnerships, and as local areas move towards accountable care systems.

However, transitioning to more formal arrangements for a single budget, assuming this also meant establishing joint commissioning arrangements, is likely to require primary legislation. Following the changes to the commissioning system introduced in 2013, there may be limited appetite for further large-scale change. Even if there were support for such a change, determining how arrangements could work in practice is not straightforward. The Barker Commission warned against reopening the long-term debate on whether the NHS should take over the commissioning of social care, or whether local authorities should commission health services.⁵ Any change would also take time. While there are international examples of how health and social care can be successfully integrated by means of a pooled budget, it is important to bear in mind that changes have taken place over the course of a decade, and they are ongoing. Additionally, they are likely to require significant financial investment.⁸²

Even within the UK, different payment incentives, frameworks and workforce cultural differences between the NHS and local government have been identified as further barriers to integration.⁷⁶

Conclusion

Although it would not guarantee more integrated services, bringing together health and social care budgets together is likely to support significant progress in this direction. However, this model itself will not address the problem of insufficient funding for both health and social care.

Table 7: Summary of the single budget for health and social care approach

Attributes	Strengths	Weaknesses
Equity/fairness	<ul style="list-style-type: none">• Would help facilitate the integration of health and social care, including aligned entitlements and joint commissioning	<ul style="list-style-type: none">• Does not in itself align eligibility rules
Economic efficiency/VFM	<ul style="list-style-type: none">• Some evidence of better outcomes for patients	<ul style="list-style-type: none">• No compelling evidence of national cost savings
Sustainability and resilience	<ul style="list-style-type: none">• Integrated decision-making across pathways may improve sustainability and resilience	<ul style="list-style-type: none">• Risk that funding for social care is directed to other parts of the system

Attributes	Strengths	Weaknesses
Acceptability and accountability	<ul style="list-style-type: none"> • Clearer single line of accountability 	<ul style="list-style-type: none"> • Risk funding is shifted between systems/that social care funding is diverted towards the NHS
Clarity/ease of use	<ul style="list-style-type: none"> • Likely to be much easier for the public to understand – many people are not aware of the approach to funding social care or the separation between health and social care until they come into contact with the system 	<ul style="list-style-type: none"> • Without changes to eligibility, there would still be confusion around access to services – in practice this could increase if a single budget was providing different services in different ways
Implementation	<ul style="list-style-type: none"> • This could build on some existing efforts, for example the Better Care Fund and Health and Wellbeing Boards 	<ul style="list-style-type: none"> • A formal change in commissioning responsibilities to support a single budget may require primary legislation

Free personal care

Box 12: Key features of this approach

- This model has operated in Scotland since 2002. Under this model, **free personal care is** provided to anyone aged over 65 on the basis of need, regardless of their level of income or savings and assets.
- The approach is different depending on whether the individual receives personal care in their own home, or in a care home:
 - Those receiving care at home are not charged for any personal care services.
 - For those who receive care in a residential setting, the local authority makes a contribution to the cost of their personal care (at a flat rate), directly to the care provider. This payment does not cover their accommodation costs, which are subject to a means test.
- This system relates to the nature and scope of the government's offer on social care, but is not a means of generating funding.

What is it?

Since 2002, Scotland has operated a system of free personal care for those aged over 65. Under this model, anyone aged over 65 who is assessed as having personal care needs is entitled to receive services to aid them with day-to-day activities, regardless of their means. Personal care tasks are defined as personal hygiene tasks (shaving, cleaning teeth), eating requirements (food preparation), mobility assistance, medical treatments (administering creams and medications), and attending to general wellbeing (dressing, getting in and out of bed).

The free personal care system is funded by general taxation and administered by local authorities. The approach is different for those receiving personal care in a care home, and those receiving it in their own home, as follows:

- Those aged over 65 who receive **care at home** are not charged for any personal care services. They may still be charged for domestic services (such as help with shopping or housework) to help with their wider social care needs, although this would be subject to a financial assessment.⁸³ Recipients are still entitled to attendance allowance.
- For those aged over 65 entitled to free personal care who live in **care homes**, the local authority pays a flat rate of £171 per week directly to a care provider. If they are also assessed as needing nursing care, the local authority pays an additional £78 per week⁸⁴. However, accommodation costs are subject to a means test (see below). Care home residents who opt to have free personal care payments forfeit their attendance allowance.

For those cared for in a care home, the accommodation element of the total cost is subject to a means test, as follows:

- Those with assets (and half of any jointly held assessable assets) above £26,250 (2017/18) must pay for all their accommodation costs.
- Those with assets below £16,250 (2017/18) qualify for support; the maximum local authority budget (paid at a standard rate across Scotland).
- Those with assets between these thresholds are expected to make some contribution in the form of 'tariff income', as in England.⁸⁵

As above, wider social care support needs such as help with shopping, help with housework and laundry are not covered by the free personal care system.

Who proposed it?

The Royal Commission on Long Term Care for the Elderly in 1997 recommended that costs of long-term care be split between personal care, living and housing costs. It recommended that the costs of personal care should be met by the state, while living and housing costs should be subject to means testing and jointly funded by individuals and the state (With respect to old age, March 1999). Subsequently the Community Care and Health (Scotland) Act 2002 implemented free personal and nursing care for people aged 65 years and older, and free nursing care for care home residents regardless of age. In response to the commission, England and Wales only implemented free nursing care, although Wales subsequently introduced more heavily subsidised personal.⁸⁹ The Scottish Government has now committed to extending the entitlement to those aged under 65.

In the run up to the 2010 election, Gordon Brown put forward proposals for the provision of free personal care for those with the highest needs, as part of plans for a National Care Service.⁸⁶ In 2014, The Barker Commission also recommended a form of free personal care in England, suggesting that all care for those with very high care needs (whether they be 'health' or 'care' needs) should be free at the point of use.⁶⁶

The Scottish Government has recently committed to extending the system of free personal care to those under 65, to take effect by April 2019.⁸⁷

Strengths and weaknesses

This section sets out the strengths and weaknesses of a system for free personal care for those aged over 65, drawing primarily on the experience of this model in Scotland.

Equity/fairness

Personal care is provided on the basis of need only

The provision of personal care to people aged over 65 in their homes is determined on the basis of need only; no one can be charged for receiving these services at home, regardless of their level of income or savings and assets. The number of people receiving personal care rose significantly in the years following the introduction of the policy, suggesting high levels of unmet need under previous arrangements. Between 2002 and 2005 there was a 10% increase in the number of local authority home care clients, and within this group the number receiving free personal care increased by 62%. This increase was unexplained by demographic trends, rates of disability or a reduction in informal care and has therefore been attributed to unmet need.⁹¹

The needs-based system also avoids the boundary between NHS and social care which operates in England. By considering a patient's functional ability, rather than their diagnosis, people with a certain level of care need will have access to services free of charge, regardless of whether their underlying diagnosis falls within the remit of NHS CHC.

However, because free personal care in Scotland is not means tested, and does not provide graded levels of support, a person who is just under the 'need' threshold who might struggle to pay for care will get no support. Interviews with local authorities revealed that the group who had the most to gain from free personal care was older people with higher incomes and greater financial resources, and those who stand to inherit their estates.⁸⁸

Similarly, under the current system there is a significant difference in the treatment of those 65 and over, and those under 65, who do not qualify for free personal care (although the Scottish Government has recently committed to extending the system to those under 65).

There continues to be regional variation

In addition, eligibility for personal care is determined by local councils, which means that in practice the level of service people receive differs according to where they live.⁸⁹ Recent financial pressures have led to more pronounced variation in services between local areas. Research carried out recently by Age Scotland found that pressures on councils have translated into delays in each stage of the system, with older people often waiting months for care assessments in Scotland. There is variability between different councils' waiting times, and there is anecdotal evidence of delayed personal care payments because local authorities have 'run out of money'.⁹⁰

Non-personal care has become more expensive

As set out above, non-personal care, or services to help with wider social care support needs – such as help with shopping, housework and laundry – would not be included in this system.

In Scotland, the introduction of free personal care appears to have led to a reduction in the provision of non-personal care, as local authorities were required to provide personal care within fixed budgets. This led to an increase in charges for non-personal care, and may have resulted in people eligible for local authority support before the introduction of the policy subsequently finding themselves reliant on informal care or privately funded care.⁹¹

Economic efficiency and value for money

System would cost more than the current system

Providing free personal care to all those aged over 65 would represent a significant increase in costs compared with the current system. When the policy was introduced in Scotland, local authorities found that they experienced not only a loss in income from those who had previously paid for their care, but also an increase in costs as a result of additional demand arising from previously unmet need.⁹²

The experience in Scotland also suggests that the model has become increasingly expensive over time; between 2003/4 and 2010/11 there was a 160% increase in spending attributed to free personal care in Scotland, despite there only being an increase in the over-65 population of 9.2%.⁹³ However, the growth rate has slowed significantly over time, with considerably smaller increases in the period since 2006/07.⁸³

In addition, some analysis suggests that the system of free personal care may have reduced the total per-person cost of accommodating Scotland's ageing population, potentially resulting in lower total government expenditure as compared with no policy being in place.⁹³ This is linked to more people being supported to live in their own homes for longer, helping prevent costly hospital admissions, and delaying the need for residential care. The number of 'occupied geriatric long-stay beds' in Scotland decreased by 39% between 2003 and 2008, and the number of 'long-stay residents aged 65+ supported in care homes' decreased by 4% between 2002/03 and 2009/10. Additionally, the number of delayed discharges between 2001 and 2010 fell by 93.2%, all in spite of growth of the over-65 demographic.⁹³

There is a question about the alternative uses of funding

It is also worth noting that in 2000, the Department of Health rejected the Royal Commission's recommendation on free personal care. This was on the argument that the resources identified for older people – all of which would be consumed by the free personal care policy, were it adopted – would be better spent on intermediate care services and other preventive and rehabilitative services. It was also argued that, given that at the time around three-quarters of those in nursing or residential care already had some or all of their personal costs met by public funds, providing universal free personal care would carry substantial costs without necessarily improving services.⁹⁴

However, there is no evidence that in recent years investment in intermediate care in England has increased in line with estimated demand, and the number of beds commissioned appears to have fallen.⁹⁵ Meanwhile the system for free social care in Scotland is due to be extended, which will involve additional investment. This may suggest that, in practice, the latter has been more successful in ensuring provision of the social care services requirement to meet people's needs. Nonetheless, it is important to note that an investment in free personal care is likely to mean less investment in other areas, such as those focused on improving quality.

Sustainability and resilience

Scotland has provided free personal care funded by general taxation for the last 15 years. Rather than scaling this back, it is now planning to broaden entitlement to those under 65. The feasibility study into the extension concluded that it could have important benefits, and may prevent younger people from declining and ultimately needing more costly care.⁸³

The free personal care system is also supportive of the longer-term vision for social care (and health) more broadly. Although it coincided with a range of policy changes, the free personal care policy is also seen as having played a key role in progress in Scotland. This was towards a shift in the balance from hospital and care homes to community care by supporting people to remain in their homes.⁹³

Acceptability/accountability

Free personal care is a very popular policy in Scotland, with the number of people receiving care growing significantly in the years following its introduction.⁹³ Research published in 2007 shows that 59% of Scots believe the government should pay for personal care, and 68% would be willing to pay an extra penny in the pound of income tax to finance it.⁸⁸

Additionally, research shows that relatives and other informal carers have welcomed the opportunity not to deliver personal care. However, rather than withdrawing support, they are instead performing other tasks such as social visits or organising outings, contributing to an overall increase in the quality of care.⁹¹

Consistent with attitudes to the existing free personal care policy, of the responses to the Scottish Government's feasibility study from members of the public, the vast majority were in support of an extension.⁸³

Ease of use/clarity and service user needs

The principles of the system for free personal care are easy for users to understand. By providing care which may otherwise have been unattainable, the free personal care system also supports the principle of choice, helping older people wishing to remain in their homes for longer to do so.

In practice, however, it can be difficult to define the remit of 'personal care'. Local authorities have interpreted the legislation differently, and the issue of food preparation being included under 'personal care' has been particularly ambiguous. In 2009, 7 years after the original act, an amendment was made clarifying that food preparation and other tasks such as defrosting, heating and serving food should not be charged for (the Community Care and Health (Scotland) Act 2002 (Amendment to schedule 1) Order 2009).

Some front-line service workers and service users consider the distinction between personal care and domiciliary care artificial. Since the establishment of free personal care, there have been some public misconceptions that all community care will be free, and that there is no need for assessment.⁸⁸

Implications for working-age people

The system for free personal care in Scotland is currently aimed only at those aged 65 and over. As such, it is likely that were a similar system introduced, this would mean little change in the care of people of working age. However, it would be possible to extend this system to include those of working age – as indicated above, the Scottish government has recently committed to extending the existing system of free personal care to include those aged under 65.⁸⁷

Considerations for implementation

The Scottish experience of implementing free personal care highlights the following issues:

Complexity

It is difficult to draw a line between nursing care and personal care, as experience in Scotland has shown. Where this line is drawn will have implications on the fairness of any system implemented, as well as cost implications.

Plans for extending the policy in Scotland to those under 65 have also highlighted the complexity and administrative burden involved in determining the split between personal and non-personal tasks for all service users, which is not otherwise done on a routine basis.⁹²

Public acceptability

Although the free personal care policy is now widely supported, around the time that free personal care was being implemented in Scotland, public consultation revealed that only 34% of people surveyed thought free personal care should be provided to everyone, and 42% supported means testing. It is thought that this may have been related to the complexity of implementing free personal care, for instance the definitional complexity of 'personal care' and its remit, difficulties surrounding the precise meaning of the act, and changes to current social security and community care arrangements.⁹⁶

Cost

Provision of free personal care would involve a significant upfront cost for local authorities.

It may also be difficult to estimate the financial impact of free personal care – there was an estimated shortfall of either £46m or £63m (depending on growth assumptions) by the fourth year of free personal care in Scotland.⁸⁹ This is particularly problematic in the current climate where there is already a shortfall in social care funding.

The Scottish experience also illustrates the difficulty in predicting demand for – and therefore the costs of – such a system. This issue has been highlighted as part of plans for extending the Scottish system to those aged under 65, as has the likely administrative burden and associated costs of determining the split between personal and non-personal tasks for all service users.⁹²

Wider context

The implementation of free personal care in Scotland was not a standalone change. It came about at a time where there was a shift in the balance of care from residential care to a home setting, improvement in joint working between health organisations and councils, and the establishment of the Care Commission, an independent regulatory body.⁸⁹

Introducing a similar change in England without a similar set of wider changes is likely to be more difficult.

Conclusion

This system would mean that personal care was provided to all people over a certain age on a consistent basis, according to need, with no distinction between social care and NHS continuing care. However, this would mean a significant increase in costs as compared with the current system in the UK. Moreover, this approach addresses only one aspect of the funding system, namely entitlement, and does not address the underlying funding issue.

Table 8: Summary of the free personal care approach

Attributes	Strengths	Weaknesses
Equity/fairness	<ul style="list-style-type: none"> Purely needs-tested system, regardless of personal financial status Avoids the boundary between the NHS and social care systems 	<ul style="list-style-type: none"> No graded support means that those just under the 'need' threshold may struggle to pay for support
Economic efficiency/VFM	<ul style="list-style-type: none"> There is some evidence that free personal care has reduced the total per-person cost of accommodating Scotland's ageing population 	<ul style="list-style-type: none"> The model has been increasingly expensive year on year in Scotland, disproportionate to growth of the older population requiring care
Sustainability and resilience	<ul style="list-style-type: none"> The Scottish government is planning to extend the scheme to under 65s 	
Acceptability and accountability	<ul style="list-style-type: none"> The policy has proven popular in Scotland and there is public support for extending the scheme to under 65s 	
Clarity/ease of use	<ul style="list-style-type: none"> In principle, a policy of free personal care to all those over 65 with care needs is easy for people to understand 	<ul style="list-style-type: none"> Difficulty defining which care tasks fall within the remit of 'personal care'
Implementation		<ul style="list-style-type: none"> Complexity related to separating personal care and nursing care Need to beware of possible side effects of reducing provision of non-personal social care. This could leave those with less severe needs without support from the local authority

Hypothecated tax for social care

Box 13: Key features of this approach

- This approach would mean a dedicated tax to fund social care services. This approach could take different forms, ranging from ‘full’ hypothecation, where spending on social care was linked directly to the revenue generated from the tax, to ‘soft’ hypothecation, where the tax would be symbolically linked to social care, but in practice the revenue raised would not be ring-fenced. Social insurance is a common form of hypothecation.
- Because this approach is very different from that taken in the health sector and in other public services, introducing this system would involve a significant shift.
- This approach relates to the way in which social care funding is generated, but would not determine the nature and scope of the government’s offer on social care.

What is it?

Hypothecation is essentially a ring-fenced tax where a funding pot is created for a specific purpose. A dedicated ‘social care tax’ is often raised in relation to funding social care. This could be a means of funding social care, if a new or additional tax was introduced, but does not address the issues of the government’s ‘offer’ on social care, or the way in which this system would be managed.

There are several types of hypothecation:

- **Full or ‘hard’ hypothecation:** where spending is directly linked to revenue raised for a specific purpose, that is, all funding for social care would come from an identified source and could be used only for social care.
- **Partial or incremental:** where revenues from tax increases are used to raise spending, as for the congestion charge and public transport.⁹⁷ Most of the funding for the service comes from other sources and is not hypothecated.
- **Soft hypothecation:** where a rise in tax is symbolically linked to a purpose, but in practice the take is not ring-fenced for that purpose.⁹⁸ For example, Gordon Brown’s increase in national insurance in 2003 and the recent local authority precept for social care.

Box 14: Social insurance

One common form of hypothecation is social insurance. Social insurance systems, often discussed as an option for funding social care, have been adopted in countries including Japan and Germany.

In social insurance systems, contributions from employees and employers build a fund that pays for social services or benefits.⁹⁹ A social insurance model may also include elements of traditional tax financing, particularly for those who cannot pay the social insurance premiums themselves. Social insurance is usually 'community-rated' – all contribute but contributions are not based on your health or care needs.

Many of the strengths and weaknesses outlined in this section refer to a social insurance approach.

Who proposed it?

Some form of hypothecation is often proposed as a way of generating new money for social care. In their manifesto for the 2017 election, the Liberal Democrats proposed an additional 1p on income tax that would be ring-fenced and directed to identified priority areas (social care, primary and 'out-of-hospital care', mental health and public health)⁶⁸. This is partial hypothecation as most health and care funding would continue to come from general taxation. However, they also proposed eventually developing a 'dedicated health and care tax' through reform of national insurance contributions, with a joint budget and spending outlined on people's payslips – ie a move to full hypothecation on a social insurance-like model.

The Communities and Local Government Parliamentary Committee recommended a review of funding for social care should include 'hypothecating national taxation (income tax, national insurance contributions, asset taxes, inheritance tax) and, in particular, the feasibility of introducing compulsory social insurance, publicly owned and administrated, on the German or Japanese model'.¹⁰⁰ The House of Lords Select Committee on NHS funding has also recently recommended 'hypothecation be given further consideration by ministers and policymakers' in its report on the sustainability of the NHS and adult social care.¹⁰¹ Outside of England, the Welsh Government has also stated it will consider raising taxes to pay for additional social care.¹⁰²

The social care precept, introduced in 2016, is also an example of soft hypothecation. This allows local authorities to increase council tax by a specific amount to raise additional funding for social care.

Another approach to hypothecation would be a 'salary sacrifice' scheme; an agreement to reduce an employee's cash payment, in return for a non-cash benefit – in this case, social care. Childcare vouchers and some pensions are examples of benefits that are subject to salary sacrifice arrangements.¹⁰³

Strengths and weaknesses

Equity/fairness

May not address fundamental issues around equity

A hypothecated tax may provide a means of funding social care, but does not of itself determine individuals' entitlements to care or the risk of catastrophic care costs they face, nor does it improve people's ability to plan and prepare for care needs. Simply hypothecating taxes for social care therefore does not answer questions over equity because:

- This will depend on the taxes used to raise funding, which may be more or less progressive.
- It does not of itself state what the 'offer' to the public is. It is quite possible, for example, to vary co-payments and charges within a hypothecated system to make it more or less generous.

Full hypothecation only makes real sense if the government sets out clearly what it is meant to pay for – ie the 'offer'. Indeed, it also needs to provide some independence around how the offer is set. Otherwise a government looking to save money in a hypothecated system can simply cut the relevant tax and drop the offer (by changing the means test, eligibility or other features). A social insurance system could include setting out clearly what people can expect to receive as part of the system.⁵

A social insurance system would typically involve contributions from employers, employees and the state, with a significant proportion of contributions coming from wage earners.⁶⁶ This has implications for intergenerational fairness and sustainability and may, for example, tax a declining working-age population to transfer resource to a better off older generation. The Dilnot Commission ruled out a social insurance scheme on the basis it would involve a large increase in public expenditure that could lead to reductions in services. This is evidenced in European countries with social insurance schemes, where financial pressures have resulted in the system having to cut back eligibility and care packages suggesting even full hypothecation leaves key funding challenges unanswered.⁴⁶

May exacerbate lack of alignment between health and social care

There is also a question about whether it makes sense to introduce a hypothecated tax for social care without taking a similar approach for health services. In addition, protection of spending for social care (or health) through hypothecation could see other groups for whom there is less public or political support lose out, for example homelessness or drug and alcohol misuse.

Economic efficiency and value for money

With the prospect of public support, hypothecation has the potential to raise additional funds for social care through increased taxation. These funds would have 'in-built accountability for public spending' and, by earmarking them for a particular purpose, could help reduce the risk of these funds being used for something else as political priorities change.¹⁰⁴

However, hypothecated taxes can be unpopular with finance ministries as they reduce their flexibility in allocating resources, for example if spending priorities change over time.⁶⁶

Hypothecation could also restrict governments' ability to stabilise the economy during a recession and to balance taxation and public spending.

Social insurance systems can add to the costs for employers. Some European countries that have implemented social insurance have had to relieve the additional burden on employers through general taxation and the Barker interim report suggested a social insurance approach in England could have a negative impact on the economy.⁶⁶ The Barker Commission did not support social insurance as a solution on the grounds that 'this would be a disruptive change that international experience suggests is unlikely to yield significant benefits'. However, the report also noted that some European countries that have social insurance systems appear to perform better as they also spend more.⁵

Sustainability/resilience

Income raised is not aligned to demand

A key weakness of a hypothecated tax is that any 'take' will rise and fall with the economy and as a result will not be aligned to changes in need or demand (although this is also true of the current system where social care budgets are based on local authority finances). One solution that has been offered is a 'stabilisation fund' which would put extra money into a fund during boom years to be used in economic downturns.⁹⁸ While creating some form of fund that can even out any boom and bust is necessary under full hypothecation there is a danger this would weaken the direct link between taxation and spending, therefore reducing the accountability and transparency of a hypothecated system.

Similarly, as discussed earlier in this paper, the amount raised through the social care precept is determined by how much of the council's overall social care spending is funded through council tax; and the existing tax base, rather than by the level of need.

Having a social insurance system, where a large proportion of contributions come from wage earners, would be affected by demographic changes and changes to 'the support ratio of workers to non-working pensioners'.⁵ The Dilnot Commission⁴⁶ ruled out a full social insurance scheme on the grounds that it would 'leave little scope for future flexibility on costs' and not be 'resilient to changes in the economic, political or social environment'. However, were a hypothecated tax based on income this could mean that those with high pensions were also contributing.

Hypothecation is not a magic bullet that will always raise sufficient money. In Germany, contributions have had to be increased to maintain coverage and most social insurance schemes, such as the one in Japan, are complemented by co-payments and sometimes general taxation.²⁵

Acceptability/accountability

It may make tax increases more acceptable to the public

Public opinion polls show rising support for increasing taxes to spend on adult social care,¹⁰⁵ leading some to argue that a dedicated tax for social care could get widespread public support. Public acceptability is often considered the most important strength of hypothecation or statutory social insurance, as raising public awareness of debates around available funding and subsequent trade-offs in service delivery may offer the best chance of building public support for raising additional funding. By identifying a specific purpose with

high levels of public support, and linking this to some sense of cost, it may be possible to encourage support for a tax rise for that purpose.⁶⁶ Of course, the opposite may also be true if the public thinks the costs are too high.

Accountability may depend on type of hypothecation

Social insurance or hypothecated tax may create a degree of political independence (or freedom from political interference) that a general tax based system may not.⁵ Ringfencing resources and ensuring that tax raised is used for a specific purpose helps clarify the link between taxation and government spending, and consequently can increase accountability of the government and therefore improve trust in the electorate.⁹⁸ The strength of this argument, however, is dependent on the type of hypothecation implemented. Full or 'hard' hypothecation may create a clear link between the total funding for social care and taxes. However, 'soft' or 'partial' hypothecated taxes are unlikely to provide any long-term protection. This is because:

- It may be difficult to establish a clear ring-fence, when most spending still falls outside of the hypothecated tax.
- Typically, political or partial hypothecation offers, for example '1p more on national insurance, which will go to social care' (as proposed by Gordon Brown). However, this only establishes a promise to spend more than was already offered and no government sets out its spending plans for more than a few years. Giving an answer to 'spending more than what' is the key challenge to partial and political hypothecation and they are perhaps best seen as elements of 'muddling along' as they provide at best short-term relief.

Ease of use/clarity

In principle, a hypothecated tax for social care would be very easy for the public to understand. As set out above however, in practice the link between a social care tax and spending on services may be less clear than it appears.

Moreover, gaining public support for the introduction of a new tax for social care is likely to be dependent on better public understanding of what social care is, and what their entitlements will be under a new system compared with the current system. Given the limited awareness of social care under the current system, this could be a key challenge.

Implications for working-age people

As working-age people are likely to have fewer opportunities to save for their care, a strength of a central taxation system is that it ensures the cost of caring for working-age people is spread across the widest pool of people. In addition, in any social insurance model built on employees' contributions, it is likely that government will need to directly contribute for those unable to pay for themselves.

However, aside from social insurance, hypothecation could work as well (or as badly) as for older people. Japan recognise the intergenerational issues by requiring workers aged over 40 to contribute.²⁵

Considerations for implementation

A hypothecated tax for social care would be a major change from the current system of public finance in the UK, with far-reaching consequences. Many of the countries which have introduced social insurance were able to build on established insurance schemes, for example for health, as in Germany where there is a long tradition of Bismarckian social insurance.²⁵ In England, a social insurance model would be difficult to establish as there is no successful precedent for such an approach. Implementing a social insurance model would be a major undertaking and a disruptive change, with high transition costs; and it would raise questions about whether it makes sense to have an insurance for social care and not for health.⁵ There is potential for this to be a volatile option as the complexities of implementation play out.

Partial or political hypothecation raise no such issues and indeed, both have occurred in the UK. However, they are best considered as part of the current system rather than any fundamental reform.

Conclusion

Public acceptability is an important strength of a hypothecated tax, as it offers the potential to gain public support to raise additional funds for social care. However, this model would require a significant shift in the existing system, and could exacerbate the lack of alignment between the health and social care systems (which is likely to make integration more difficult). Whether the gains from hypothecation are worth the disruption is a key question and its potential benefits are largely restricted to a fully hypothecated system, which is exactly where its key disadvantages are also clearest.

Table 9: Summary of the hypothecated tax for social care approach

Attributes	Strengths	Weaknesses
Equity/fairness	<ul style="list-style-type: none">• Depends on the source of the tax and the offer it pays for	<ul style="list-style-type: none">• Depends on the source of the tax and the offer it pays for
Economic efficiency/VFM	<ul style="list-style-type: none">• May better reflect the public's intentions on funding	<ul style="list-style-type: none">• Reduces flexibility in national spending• In the case of social insurance – it is an employment-based system and therefore can be distortionary• Transition and administrative costs are likely to be high
Sustainability and resilience	<ul style="list-style-type: none">• May protect access and funding more effectively	<ul style="list-style-type: none">• Some social insurance systems have struggled with affordability

Attributes	Strengths	Weaknesses
Acceptability and accountability	<ul style="list-style-type: none"> • Linking tax to a specific issue can help with public acceptability – likely to win support for tax increase • Accountability clear (depending on type of hypothecation) 	<ul style="list-style-type: none"> • Strength of argument depends on type of hypothecation – funding not always linked to issue in practice
Clarity/ease of use	<ul style="list-style-type: none"> • In principle, a dedicated tax for social care is easy for people to understand 	
Implementation		<ul style="list-style-type: none"> • Significant change from current system and likely to be highly disruptive

Summary of funding approaches

		Model				
		Improving current system	2017 Conservative proposals	Single budget	Free personal care	Hypothecated tax
Attributes						
Equity/fairness	Strengths	<ul style="list-style-type: none"> Limited resources are focused on those with the lowest means, and those with the highest needs 	<ul style="list-style-type: none"> Cap protects people from very high care costs Greater protection for homeowners in residential care (means-test threshold raised) Single threshold at £100,000 more generous than minimum threshold of £14,250 	<ul style="list-style-type: none"> Would help facilitate the integration of health and social care, including aligned entitlements and joint commissioning 	<ul style="list-style-type: none"> Personal care provided on the basis of need, not means Avoids boundary between the NHS and social care systems on personal care 	<ul style="list-style-type: none"> Depends on the source of the tax and the offer it pays for
	Weaknesses	<ul style="list-style-type: none"> Does not protect people from very high care costs Evidence of rising unmet need and fewer people receiving publicly funded care Entitlement for health and social care is not aligned Variation in provision and recent measures (eg precept) have exacerbated inequalities 	<ul style="list-style-type: none"> Individual spend up to cap may still be high Does not address lack of alignment between health and social care 	<ul style="list-style-type: none"> Does not in itself change rules around eligibility 	<ul style="list-style-type: none"> No graded support means that those just under the 'need' threshold may struggle to pay for support 	<ul style="list-style-type: none"> Depends on the source of the tax and the offer it pays for

		Model				
		Improving current system	2017 Conservative proposals	Single budget	Free personal care	Hypothecated tax
Attributes						
Economic efficiency/VFM	Strengths	<ul style="list-style-type: none"> Low unit costs 	<ul style="list-style-type: none"> Current incentives for domiciliary care are lost 	<ul style="list-style-type: none"> Some evidence of better outcomes for patients 	<ul style="list-style-type: none"> Some evidence policy in Scotland has reduced total per-person cost of accommodating ageing population 	<ul style="list-style-type: none"> May better reflect the public's intentions on funding
	Weaknesses	<ul style="list-style-type: none"> Separation between health and social care leads to 'cost shunting' between the two 		<ul style="list-style-type: none"> No compelling evidence to suggest national cost savings 	<ul style="list-style-type: none"> Model increasingly expensive year on year in Scotland, disproportionate to growth of the older population requiring care 	<ul style="list-style-type: none"> Reduces flexibility in national spending Employment-based systems (SHI) can be distortionary
Sustainability and resilience	Strengths	<ul style="list-style-type: none"> Local authorities have some flexibility over spend 	<ul style="list-style-type: none"> Range of features may provide governments with flexibility – ie to change floor and cap as required 	<ul style="list-style-type: none"> Integrated decision-making across pathways may improve sustainability and resilience 	<ul style="list-style-type: none"> Scottish government has committed to extend the scheme to under 65s 	<ul style="list-style-type: none"> May protect assets and funding more effectively
	Weaknesses	<ul style="list-style-type: none"> System requires 'topping up', and recent measures are not sustainable –eg precept 	<ul style="list-style-type: none"> Flexibility also makes it easy to reduce generosity 	<ul style="list-style-type: none"> Risk that social care funding is directed to other parts of the system 		<ul style="list-style-type: none"> Some systems have struggled with affordability

		Model				
		Improving current system	2017 Conservative proposals	Single budget	Free personal care	Hypothecated tax
Attributes						
Acceptability and accountability	Strengths	<ul style="list-style-type: none"> Care Act was widely support 	<ul style="list-style-type: none"> Public likely to welcome a cap on costs and higher means test 	<ul style="list-style-type: none"> Clearer single line of accountability 	<ul style="list-style-type: none"> Policy has proven popular in Scotland and there is public support for extending the scheme to under 65s 	<ul style="list-style-type: none"> Linking tax to a specific issue can aid public acceptability – help win support for tax increase Accountability is clear (depending on type of hypothecation)
	Weaknesses	<ul style="list-style-type: none"> Public understanding is poor 	<ul style="list-style-type: none"> Argument that having a cap would provide certainty – people will know the extent of the costs 	<ul style="list-style-type: none"> Risk funding is shifted between systems/that social care funding is diverted towards the NHS 		<ul style="list-style-type: none"> Strength of argument depends on type of hypothecation – funding is not always linked to issue in practice

		Model				
		Improving current system	2017 Conservative proposals	Single budget	Free personal care	Hypothecated tax
Attributes						
Clarity/ease of use	Strengths		<ul style="list-style-type: none"> Cap may be complex, though the single floor reduces complexity 'Metering' up to the cap is complex 	<ul style="list-style-type: none"> Likely to be easier for the public to understand – many people are not aware of difference in approach to funding 	<ul style="list-style-type: none"> In principle, policy is easy for public to understand 	<ul style="list-style-type: none"> In principle, easy for the public to understand
	Weaknesses	<ul style="list-style-type: none"> System is complicated for people to understand Not well integrated with other care and support 	<ul style="list-style-type: none"> Existing provisions in the Care Act would make transition easier 	<ul style="list-style-type: none"> Without changes to eligibility there would still be confusion around access to services 	<ul style="list-style-type: none"> Difficulty defining which care tasks fall within the remit of 'personal care' 	

		Model				
		Improving current system	2017 Conservative proposals	Single budget	Free personal care	Hypothecated tax
Attributes						
Implementation	Strengths	<ul style="list-style-type: none"> No transition phase required – minimal disruption 		<ul style="list-style-type: none"> This could build on some existing efforts, for example the BCF and Health and Wellbeing Boards 		
	Weaknesses		<ul style="list-style-type: none"> Concern around relying on deferred payment scheme, given current variation 	<ul style="list-style-type: none"> Any formal change in commissioning to support a single budget may need primary legislation 	<ul style="list-style-type: none"> Complexity of separating personal care and nursing care Possible unintended consequences of reducing provision of non-personal social care 	<ul style="list-style-type: none"> Significant change from current system and likely to be highly disruptive

Conclusion

This interim report has looked at the funding of social care from two broad perspectives. Firstly, by looking at the attributes by which we should assess any funding system and by considering three key issues that are often confused in the ongoing discussion around social care, namely the following.

- What is the offer to the public and users that this money pays for? (or, what is the government responsible for)
- Where does the money come from?
- Who spends this money and how?

Secondly, by considering five current models of funding social care, models chosen either because they exist already in the UK (what we term 'improving the current system' and the Scottish model of providing free personal care), alongside hypothecation for social care, a single budget for health and social care, and the proposals put forward by the Conservative Party in the 2017 general election.

How do these five alternatives measure up?

Almost everyone agrees that the current system for funding social care is inadequate. However, for such a widely disliked system it has proved remarkably difficult to reform and in practice will be with us for some time, even if the government decides on more radical reform. The combination of poor understanding of the current system along with the potentially high implementation and political costs associated with wholesale reform has led repeated governments to tinker at the edges, find a little more money, and move the problem down the track for a few more years. Given this, we suggest that there are two key issues arising from the assessment of the current system:

- Firstly, that alongside the search for a long-term solution to funding social care, there is a more rigorous attempt to ameliorate the short-term problems with the current system. This, of course, includes providing adequate funding to keep the existing system functioning as well as it can.
- Secondly, social care is poorly understood by the public and this has undermined some previous efforts at reform. Indeed, while there have been many policy ideas on social care funding, none of these has been successfully translated into deliverable reform – suggesting that it is not only the content of proposals that is important, but the process of achieving reform itself. Any attempt at more fundamental change must build up from a systematic drive to engage with the public to build, at least temporarily, sufficient groundswell of support (or grudging acceptance), to allow reform to happen. In practice this will depend on gaining support for the underlying principles of the system, as much as on policy details.

Hypothecated funding – often through social insurance – is a route some other countries have taken on social care in response to the first of our questions above. It remains for many the gold standard of ensuring a long-term settlement free from the ups and downs of boom and bust. Yet the UK does not, in general, hypothecate taxes and does not run a social insurance system. With this context, it's not the advantages of hypothecation that need focus, it's the disadvantages:

- To provide a long-term solution to funding, hypothecation needs to be 'full' – ie that all social care funding is derived from it. Partial hypothecation, such as adding 1p to income tax, only provides a short-term answer.
- Balancing the revenues from the hypothecated tax (which may vary year on year) with social care spending will require some form of independent 'fund' so surpluses and deficits can be passed from year to year.
- Alongside identifying what taxes will contribute to social care, to work, hypothecation needs to be clear about the 'offer' as well and provide some certainty around it. Otherwise, governments looking to save money can simply alter the 'offer' and shift more of the burden back to individuals and families.
- Hypothecating social care funding probably only makes sense if health goes into the same system.

For other countries that already run social insurance systems for health (or other services), these challenges are not particularly great. For the UK, that does not, they represent a major shift in the whole approach to public finance. Unless politicians and the public are willing to sign up to the implications of full hypothecation, then it risks distracting attention from more realistic options to the challenge of funding (health and) care.

A single budget for health and care makes good sense for many reasons and as a result, successive governments have attempted to narrow the divisions between these two vital areas of public service. However, simply merging budgets:

- does not of itself generate additional revenue for health or care. It may provide better value for money, either through lower costs or through better outcomes. However, even where it does, it is not realistic that such savings could fill the gap on funding. A single budget may be the right answer, but to a different question.
- while leaving underlying funding and the offer as they are will only be a partial solution even to integrating care at local level. As long as there are such deep divides between the eligibility for free NHS care and means-tested social care, there will remain fundamental differences between the two systems. While removing these divisions may be too challenging, it is fair to ask how far any proposed social care funding and offer succeeds in reducing the divisions between health services and care services.

The 2017 Conservative proposals did something we have not seen many times in recent years: they tried to be clear exactly what the 'offer' for social care should be. At the time of the election, they also pointed to some areas of savings they thought could pay for this changed offer. That for many (but not all) current and future users of social care the Conservative proposals were a definite 'win' is clear, even if they were not necessarily interpreted as such at the time. The relevant question may be whether this was the best use of additional public money on social care, a question made more complicated by the current

complexity of social care funding and, to an extent, the complexity of the Conservative proposals too. This is something we will return to in next steps.

Scotland has provided free personal care for more than a decade and seems happy with the approach. It is clearly an 'offer' rather than a source of funding in itself. Whether this offer is better than, for example, the Conservative Party proposals depends on its costs but also how far it fits with public and user expectations. Again, this is something we will return to in next steps.

Overall, a full answer to the social care funding challenge needs to state where the money is to come from, what the offer is that it pays for, and how is it to be operationalised and managed. To the last question arguably the single budget for health and care should be the answer. But to the first two, all the options here only provide part of the answer (if any at all).

Next steps

The next phases of this work between the Health Foundation and The King's Fund will look to fill in the gaps in some of the options discussed in this interim report. We will look to:

- set out the **funding required** for social care in the years ahead
- **model a wider set of options for filling this gap**, including investigating whether there are existing elements of public expenditure that could be used to meet any shortfall. We will also consider again whether these options, identified by focusing on older people, could be appropriate for services for people of working age
- **work with the public** on the social care offer and how to pay for it.

This will supplement the work in this interim report, aiming to provide analysis that will help answer the three core questions on social care: where to find the money, what to offer the public, and how to organise care. This final report will be published in spring 2018.

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