SECURING GOOD CARE FOR MORE PEOPLE

Options for reform

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The King's Fund

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Executive summary

Background – the case for change

- Much has changed since the publication by The King's Fund of the seminal review *Securing Good Care for Older People* (Wanless 2006). Unmet need has increased, as has pressure on resources. The accelerating pace of demographic and social change has strengthened the need for reform, not only for older people but also for younger adults. This is a long-term issue and current spending restraints are not an excuse for inaction. Politicians need to look beyond the current economic climate.
- Doing nothing is the least palatable option. Projections show that the cost of the existing system will almost double by 2026, yet without any improvement in the outcomes that could be achieved through radical reform. The Green Paper *Shaping the Future of Care Together* (HM Government 2009b) recognises the need for change. It puts forward a vision for a system that is described as fair, simple and affordable, delivered through a National Care Service. The publication of the Personal Care at Home Bill, and the Conservative Party's pledge to introduce a home protection scheme, also reflect high levels of political interest.
- This report builds on the 2006 review. It marshals fresh evidence of the compelling need for reform including projections drawn from dynamic modelling. It reinforces the conclusion of the original report – that reform must be based on a partnership between the individual and the state and that it must be radical to improve outcomes, access and fairness while remaining affordable.

Options for change – costs and outcomes

- Improvement in analytical tools since 2006 have made it possible to model the implications of funding and service reform, including a more detailed breakdown of costs, numbers of people helped, implications for levels of unmet need, the rate at which people have to draw on their savings, and whether they are net beneficiaries financially from any change. The analysis has been applied to three funding options over the period 2015–2026: the existing system unreformed; free personal care (FPC) and a revised, less generous version of the 2006 review's partnership model in which the state funds 50 per cent of everyone's care and support costs and matches every £2 contributed by the individual with a further £1.
- In summary, the projected **costs** of public spending on social care for older people (using 2007 prices) for each of the options modelled are:
  – **the existing system**, based on current levels of support: projected to cost just over £8.1 billion in 2015, rising to £12.1 billion by 2026 – approximately a 50 per cent increase.

  - **The King's Fund partnership model**: projected to cost £10.1 billion in 2015, rising to £15.5 billion by 2026 – 90 per cent more than the existing system would cost in 2015.
  - **free personal care** (unsurprisingly the highest cost model): projected to cost £10.7 billion in 2015 rising to £16.8 billion by 2026 – an increase of just under 110 per cent.

- The costs could be offset if accompanied by reform of Attendance Allowance. By 2026 public spending under the partnership model would be £12.6 billion (£15.5 billion without savings from Attendance Allowance), free personal care £13.9 billion (£16.8 billion) and the existing system £9.2 billion (£12.1 billion) in 2026.
- Both the partnership and FPC options would offer a much more **universal** system of support than the existing system. Almost two-thirds more people would receive public funding. However the higher cost of FPC does not significantly increase the number of people helped.
- An unreformed system would see **unmet need** continue to rise. The Partnership50% model (a 50 per cent guaranteed level and a £1 matching contribution for every £2 individuals pay themselves) would halve the amount of unmet need in 2015 compared with the existing system, while free personal care would reduce it still further.
- Going further to tackle **unmet need**, offering higher levels of support ('benchmark' packages) would see costs rise sharply – a 35 per cent extra cost to the state (in 2014/15). Unmet need levels would fall by 32 per cent. Whatever funding system is adopted, it is clear that the costs of meeting unmet needs will be pose a greater challenge that the costs of changing demography alone.
- The extent to which people have to **spend their savings and assets** to pay for care is greatest under the existing means-tested system, especially for residential care and for people on middle incomes and savings of more than £23,000. In contrast, the partnership model helps these people significantly. Spending of assets is lowest under free personal care because charging is minimal.
- Assessing who would **gain and lose** from switching to a different funding system confirms that moderately wealthy people and above – particularly those who would have no support under the current system – would do much better. They would pay lesser charges for the same value of care under both partnership and FPC compared with the current system. In fact, it is projected that the most well-off would be the biggest gainers at the point of need under FPC compared with partnership and the current system. Poorer people would gain by a more modest amount. This reflects the generosity of free personal care in which the state covers all personal care costs, irrespective of income or wealth. If extra funds are raised through a progressive tax or contribution system, then these effects would be reduced.
- For **working-age adults** public spend on social care is projected to reach £6.6 billion in 2014/15, rising to just over £8.8 billion in 2025/6. However these figures are based on current levels of support, and more work is needed to develop the costs of higher levels of 'benchmark' support. Although it seems likely that working-age people will continue to receive care and support free at the point of use, it raises questions about the overall amount of additional public funding needed to meet growing needs and expectations, and the dangers of a system that remains separate from older people's care funding. The aspirations of working-age people with care and support needs should be central to the design of a new system.

- Most of the options considered in this report are more expensive than the current system, but produce better outcomes overall. It has not been possible to assess the impact of the Green Paper's funding options as the underpinning data and assumptions have not been published.

Reforming Attendance Allowance

- The conclusion of the 2006 review that there was scope for improving the targeting of **Attendance Allowance** and its alignment with the care system remains valid. The amount of public money spent on AA is significant and growing and in view of poor prospects for the public finances, the argument for its inclusion in the redesign of care funding is compelling. The policy shift towards personal budgets as the default operating model for adult social care creates a further argument for rationalising and simplifying disconnected funding streams.
- Reform of AA, by limiting it to those in receipt of Pension Credit, would ultimately free up almost £3 billion a year by 2026; existing recipients would be protected, but in the future some people would be hypothetical 'losers' (some people with income above the Pension Credit levels would lose entitlement).

Conclusions and a way forward

- Radical reform would improve outcomes that are not just about the costs of the system, but also about the numbers of people receiving help, the amount of unmet need, the extent to which people have to draw on their savings and assets to pay for their care, and who gains and loses from funding reform.
- Both FPC and The King's Fund partnership model would help many more people, albeit at a higher cost, than the existing system; FPC has attracted considerable support and is the one option that will be most clearly understood by the public, but it involves the highest cost to the public purse without a commensurate improvement in outcomes. Although everyone gains under FPC, the wealthiest gain the most. However, a progressive tax or contribution system would reduce these effects.
- The need for the costs of care to be shared responsibly between the individual and the state should be a founding principle for reform. The choice of which funding option to pursue will involve a delicate balancing of political, economic and administrative criteria. On balance, our view is that a revised version of the original partnership model offers the best outcome in relation to costs, and one that can be blended with other funding options to reflect the changing nature of trade-offs between costs, affordability and simplicity.
- The increase in public funding is high for all of the options we have modelled, and if unmet need is addressed is higher still. For the years between 2015 and 2026, the Partnership50% model would require an annual average increase of £2.5 billion more public spending than the current system and free personal care would require an increase of £3.5 billion. Offering higher levels of support would add a further £4–5 billion each year. These amounts are less daunting when viewed in the context of the current public sector borrowing total of £178 billion a year, and other levels of spending on older people. What is affordable is subject to political judgements about the relative priorities any government should give to competing claims on limited public funding.

- Fundamental reform to achieve a more sustainable funding system is both essential and possible, through four steps:
  - adopting a staged approach to funding reform
  - a fundamental spending review to achieve a new settlement for older people
  - ensuring that the reform of funding is accompanied by reform of delivery.
  - driving comprehensive reform by establishing a strategic, long-term framework for change, which will require an all-party road map for reform.

Four years on from our original review, politicians are at last giving reform of the care and support system the priority it deserves. It is essential that the momentum gained is sustained and that the next government delivers the radical reforms so desperately needed. Not to do so would be to betray the current and future generations of people who rely on the care and support the system provides.

1 Introduction

The purpose of this report is to:

- refresh and update The King's Fund's 2006 review *Securing Good Care for Older People: Taking a long-term view* (Wanless 2006), using a dynamic micro-simulation model to provide new estimates of projected costs and benefits
- reflect new policy developments and the implications of political and financial uncertainty
- assess the funding options set out in the Green Paper *Shaping the Future of Care Together* (HM Government 2009b)and how these compare to the funding options modelled in this report.

Recognition of the need for fundamental reform of social care funding has never been greater. The publication of the long-awaited Green Paper *Shaping the Future of Care Together* (HM Government 2009b) represents the government's response to rising concern about current arrangements for funding long-term care and support. It puts forward a vision for a system that is described as fair, simple and affordable, delivered through a National Care Service. It includes a commitment to publish a White Paper in 2010 that will set out detailed proposals for the new national service. The publication of the Personal Care at Home Bill, and the Conservative Party's pledge to introduce a home protection scheme, also reflect high levels of political interest in social care.

However, the Green Paper has been published at a time of heightened political uncertainty and in a tough economic climate in which the prospects for future levels of public spending seem bleak. The road to reform of social care funding has been tortuous and there is much distance to be travelled. There is little prospect of major change before 2014; the clamour of competing priorities facing the incoming government, alongside the intrinsic complexities and trade-offs in changing current arrangements, pose a real threat to securing real reform.

The purpose of this report is to reassert the case for change, building on earlier work published by The King's Fund. It marshals the fresh evidence of the compelling need for reform that has amassed since the seminal review *Securing Good Care for Older People: Taking a long-term view* (Wanless 2006).

The need for change is not new. The current system originated in the 1948 National Assistance Act and many of its problems were examined over a decade ago by the Royal Commission *With Respect to Old Age*, established to explore 'a way to fund long-term care which is fair and affordable for the individual and the taxpayer' (Royal Commission on Long Term Care 1999). However its principal recommendation – to provide free personal care through general taxation – was not accepted by the government.

Evidence of dissatisfaction with the system – perceived as 'irrational, confusing and unjust' (Caring Choices Coalition 2008) and 'incoherent, unfair and unsustainable' (Hirsch 2006) – continued to grow. Although HM Treasury commissioned Sir Derek

Wanless to carry out a systematic analysis of the future funding needs of the NHS, the government did not commission a similar exercise in relation to social care. The King's Fund established its own review and in April 2006 published *Securing Good Care for Older People: Taking a long-term view* (Wanless 2006), a review of social care spending requirements for older people over the next 20 years. It concluded that a 'partnership' model of funding was the best, fairest and most cost-effective way of delivering a minimum level of care to people.

Subsequently The King's Fund was instrumental in bringing together 15 other organisations from across the long-term care sector to form Caring Choices, a coalition that sought to engage the public in debate about what care should be provided and how it should be funded.

The need for fundamental reform was finally acknowledged by the government in the 2007 Comprehensive Spending Review (HM Treasury 2007):

> *….recent reports from Derek Wanless for The King's Fund, the Joseph Rowntree Foundation and others have made important contributions to the growing debate around the need for change to the care and support system for older people. …The government welcomes these assessments but also believes that the case for reform might be extended to all those adults receiving care and support. It will now undertake work to look at reform options and consult on a way forward.*

Following a government engagement exercise in 2008 (Central Office of Information, Ipsos MORI and Synovate for HM Govt 2009) with the public and stakeholders, the government published the Green Paper on the national care service *Shaping the Future of Care Together* (HM Government 2009b).

Much has changed since The King's Fund 2006 review including:

- further evidence of worsening pressures on the social care system – tighter eligibility criteria, fewer people receiving help, greater unmet need, and the growing impact of recession on needs and resources
- the government's extension of its commitment to reform the system for adults of all ages, not just older people
- a new policy programme, *Putting People First*, to transform the delivery of social care, signalling a new delivery model based on personalisation
- fresh policy initiatives in relation to dementia, carers, and learning disability
- world economic recession, the near collapse of the UK banking system, and soaring levels of public debt casting a shadow over future levels of public spending, inevitably affecting views about what is affordable and sustainable
- the prospect of a general election by June 2010 and the implications of a different set of political priorities
- improvements in the simulation model used in the 2006 review, and updated population figures, enabling us to make better projections of need and outcomes.

Hence there is a need to revisit the case for change, reiterated in the 2006 review, and to develop a fresh analysis that takes full account of all of these developments.

Background to The King's Fund's original review

The 2006 review (Wanless 2006) found one million people aged 65 and over were already using publicly funded social care services in England and that councils were spending around £8 billion a year on means-tested services.

It noted that billions more were being paid out in benefits to older people with disabilities, and that older people themselves were spending around £3.5 billion on home and residential care.

Yet the year-long review concluded that the social care system was 'falling short' of the government's aspirations for it: to give people choice over the services they received, to promote their independence, and to prevent them needing hospital or residential care.

It also found there was 'widespread dissatisfaction' with the means-tested funding system and the 'unfairness' of the way in which funding rules were applied, which had led to a 'postcode lottery' across England.

Against this backdrop, the review looked ahead to the next 20 years, when the proportion of older people in the population is set to increase dramatically.

The report concluded that although people are living longer, they will experience more years of ill-health, so the number of people needing help with one or more of the activities of daily living – such as washing or going to the toilet – is likely to double by 2025.

To judge the impact of providing care for them, the review developed a new measure, the ADLAY (activities of daily living adjusted year), to try and quantify the gain in quality of life that individuals enjoy over a period of time due to the help they receive with the activities of daily living. One unit of ADLAY was set to represent an improvement in the quality of life equivalent to moving from a situation where no activities of daily living (ADL) needs are met to one where they are all fully met, and was valued at £20,000 per year. The review assumed therefore that services should be provided up to the point where it would cost more than £20,000 to yield one extra ADLAY.

The review then modelled three scenarios.

Scenario 1 assumed that patterns of social care services and outcomes will be broadly the same in the future as they are now. To deliver scenario 1 in 2022, it calculated that total spending would have to rise to £24 billion (1.5 per cent of GDP).

Scenario 2 was more ambitious and assumed that changes could be made to the social care system to deliver, for all those in need, the highest possible personal care and safety outcomes that could be justified given their cost. This would require spending of £29.5 billion in 2026 (2 per cent of GDP).

Scenario 3 was more ambitious again; it built on scenario 2 by assuming that the social care system would also deliver better outcomes in terms of social inclusion and a broader sense of well-being. Spending would need to rise to £31.3 billion (2 per cent of GDP).

Finally, the review considered how these increases might be funded. It looked at a number of options, from the unpopular means-tested model, to a partnership model in which taxpayers and older people shared the cost of care, to a 'free' model similar to that introduced in Scotland.

After examining the fairness, efficiency and sustainability of the different options, and the amount of choice and dignity they would offer those needing care, the 2006 review concluded that a partnership model would be the best approach.

The government would fund a guaranteed level of care, but people could top this up. For every £1 they topped up, the government would add another £1. The review argued that this would shift attention from people's means to their needs, ensure their basic needs were met and produce better value for money – while still giving people an incentive to save for their old age – although the partnership model would be more expensive than the present system.

In public engagement events organised by the Caring Choices coalition around 75 per cent of participants supported some kind of partnership model, although there was less agreement on what this should look like.

The 2006 review has been influential in shaping opinions and views about funding options. The central concept of the partnership model – that funding of care should be a shared responsibility between the state and the individual, the separation of accommodation or 'hotel' costs from care costs, and the suggestion of reconsidering the use of Attendance Allowance as part of the overall funding mix – were all reflected in the Green Paper *Shaping The Future of Care Together* (HM Government 2009b).

2 Trends and developments

Key points

- The need for reform is greater now than it was at the time of the 2006 review. Unmet needs have grown and the pressures on services and budgets are mounting. Demography is fuelling extra demands from rising numbers of younger people with care and support needs which have to be considered alongside those of an ageing population.
- Although the policy framework has been refashioned to promote a shift towards personalisation and a different delivery model, the fiscal environment has worsened dramatically. The backcloth against which funding options can be evaluated is fundamentally altered.
- The principal conclusion of the 2006 review that the social care system required fundamental reform is universally agreed on but without consensus about possible solutions. This has generated new policy thinking and increased attention by the political parties, culminating in the publication of a Green Paper and separate specific announcements at the 2009 Labour and Conservative Party conferences.

Introduction

This section sets out what has changed since the 2006 review and the different circumstances in which the reform of social care funding and delivery must now be viewed. In summary these are:

- policy developments, including the *Putting People First* initiative and the transforming adult social care programme
- further evidence of the scale of need and unmet need
- the accelerating pace of demographic and social change
- the colder financial climate arising from the economic downturn and deterioration of public finances
- new ideas and thinking about funding options
- lessons from other countries, including the experience of free personal care in Scotland
- emerging evidence of the value of prevention and early intervention.

Policy developments

In 2007 the government initiated a major transformation of adult social care, detailed in the ministerial concordat *Putting People First* (HM Government 2007). This set out a radical prospectus for change commanding wide support – a range of stakeholders across the social care sector and six government departments are signatories – which lent some

support to its claim that 'It seeks to be the first public service reform programme which is co-produced, co-developed, co-evaluated and recognises that real change will only be achieved through the participation of users and carers at every stage' (HM Government 2007). The shared ambition is to put people first through a radical reform of public services, enabling people to live their own lives as they wish, confident that services are of high quality, safe and promote their individual needs and preferences for independence, well-being and dignity. The concordat aims for high-quality support that is universal and available to every community. The aim is that people who use social care services, and their families, will increasingly shape and commission their own services. Personal budgets will ensure people receiving public funding use available resources to choose their own support services. The concordat includes objectives for a universal information, advice and advocacy service, and a common assessment framework.

The commitment to personalisation as the cornerstone of government policy for adult social care was subsequently confirmed and elaborated in a local authority circular (Department of Health 2008b). The key implications for the future development of policy and practice can be summarised as:

- a shift to prevention and early intervention to promote well-being and independence
- access to universal information and advice
- a new model of self-directed support, driven by self-assessment and person-centred planning
- personal budgets for all entitled to publicly funded care
- a leadership role for councils and their directors of adult social services to achieve whole system change with partner organisations
- a fundamentally different operating model from traditional services that is based on personalisation.

It is significant that four of the six elements of the proposed National Care Service in the *Shaping the Future of Care Together* Green Paper (HM Government 2009a) – prevention services, joined-up services, information and advice and personalised care support – are already established policies through *Putting People First* (HM Government 2007) and are being implemented by local councils.

Three other important strategies have since been published which, although not specifically about care and support, are directly relevant to the current policy debate about the funding of social care:

- *Carers at the Heart of 21st Century Families and Communities* – a new cross-government strategy set out action over the next 10 years covering breaks, income, information and advice, the workplace, training for the workforce, access to employment, emotional support, the health of carers and the specific needs of young carers (Department of Health 2008a).
- *Valuing People Now* – a three-year cross-government strategy for people with learning disabilities signalled that the numbers of people using services is set to increase by more than 50 per cent, to 223,000, by 2018 (Department of Health 2009e).
- *Living Well with Dementia: A national dementia strategy* – an ambitious strategy recognising that dementia numbers will double over the next 30 years to 1.4 million and that costs will treble to more than £90 billion a year (Department of Health 2009a).

Thus the policy environment is very different from the one in which the 2006 review took place, and the focus on personalisation is a radical departure from the traditional ways in which services have been commissioned and provided. This raises new questions, about what is funded, not just how, and how reform of funding will be connected to transformed delivery.

Need and unmet need

The scope and scale of pressures facing adult social care have intensified since the 2006 review.

First, concern has continued to mount about the difficulties people describe in getting basic help, the growing number of people deemed ineligible for council-funded care and the application of the Fair Access to Care Services (FACS) framework. Increasing demand on social care budgets is well documented and is continuing (York Consulting 2009). Councils have sought to contain demand by restricting access to services. By 2006, fewer households were receiving supported home care than in 1997, and fewer older people were receiving publicly funded care at home than in 2003. By 2007 72 per cent of councils had set the threshold at 'substantial' or 'critical'. A major review carried out by the Commission for Social Care Inspection for the government confirmed the extent to which the current system is failing to meet needs. Responses to an online survey suggested that

- 25 per cent of those seeking help fell outside of councils' eligibility criteria
- of those not receiving help, 35 per cent said they managed without; 32 per cent got help from family members; 23 per cent made private arrangements and 10 per cent were helped by a voluntary organisation
- one in five of people identifying themselves as carers, and one in eight of those who could benefit from social care were not offered an assessment of their needs, in one-third of such cases on the erroneous basis that they were not financially eligible for help; thus many are diverted from the system at a very early stage
- of those who did meet eligibility criteria, only 30 per cent reported receiving all the help they needed; around half got some help (Commission for Social Care Inspection 2008).

Second, the 2006 review did not address the needs of working-age adults; it is now clear that these represent a major pressure for councils. The most recent budget survey of English councils showed that learning disability was one of the most significant areas of demand and cost pressure, and most were expecting additional pressures as a result of demographic change (*see* Table 1 below). In 2008/9 council spending on learning disability services alone increased by 10 per cent (NHS Information Centre for Health and Social Care 2009).

Table 1 Cost estimates due to demographic change, 2009/10

User group	Cost to authorities as a whole (£m)	Cost to authorities on average (£m)
Older people	71.511	0.477
People with learning disabilities	145.593	0.970
People with mental health illness	15.145	0.101
People with physical disabilities	25.145	0.168
Total	257.394	1.715

Source: York Consulting 2009

In 2007/8 council expenditure on older people's care services actually fell by 2 per cent, despite rising numbers, while their expenditure on learning disabilities rose by 2 per cent (NHS Information Centre for Health and Social Care 2009). The Commission for Social Care Inspection had previously noted that the number of older people using community and residential services dropped overall from 867,000 people in March 2003 to 827,000 in 2007 – at a time when the population aged 75 and over increased by 5 per cent (Commission for Social Care Inspection 2009). At the same time, the eligibility thresholds that councils use to prioritise access to care have been increasing.

These trends suggest that it is no longer tenable to view the reform of social care funding as predominantly an issue for older people, and that it will be impossible to achieve a 'fair, simple and affordable' system without addressing funding pressures in the round.

Demographic and social change

Updated demographic projections and other research confirm that the need for care and support is set to rise over the next 30 years, both among older people and adults of working age. The projections show:

- the need for social care services for adults with learning disabilities rising between 3–8 per cent annually between 2009 and 2026 (ie, an additional 47,000–113,000 adults over the next 10 years) (Emerson and Hatton 2008). If anything these appear to be conservative estimates. The government's *Valuing People Now* strategy says that numbers of people using services is set to increase by more than 50 per cent by 2018 (Department of Health 2009b)
- growth in the number of adults with profound and multiple learning disabilities – an average 1.8 per cent annual increase from 2009 to 2026, 37 per cent over the whole period (Emerson and Hatton 2008)
- higher numbers of learning disabled younger people (aged 18–64) – rising from around 203,000 in 2005 to around 245,000 in 2041 – a 20.6 per cent increase, and higher numbers of physically and sensory impaired younger people, rising from 2,755,000 in 2005 to 3,235,000 by 2041, a 17.4 per cent increase (Wittenberg *et al* 2008).

Demographic projections for older people, updated since the 2004-based projections, confirm that the population is continuing to age (*see* Figure 1 opposite), and that the numbers of 'oldest old', those over 85, is growing at an even faster rate (*see* Figure 2 opposite).

In summary:

- the number of people over 85 will double by 2026 to almost 2 million; the number of people aged over 100 will have quadrupled
- currently, there are around four people under 65 for every person aged over 65. By 2029, there are expected to be three people under 65 for every person over 65
- evidence suggests that although life expectancy is increasing, healthy life expectancy is not increasing at the same rate. People are spending a longer time living with conditions that seriously reduce their quality of life, such as arthritis, the effects of a stroke, or dementia. Current trends in obesity and other lifestyle-related diseases will also increase the need for care.

These trends confirm that the social care system will experience sustained pressure in meeting the needs of increasing numbers of people across all ranges with care and support needs (*see* Figure 3 on p 10).

Figure 1 Projected growth in population aged 65 years+, 2006–2029

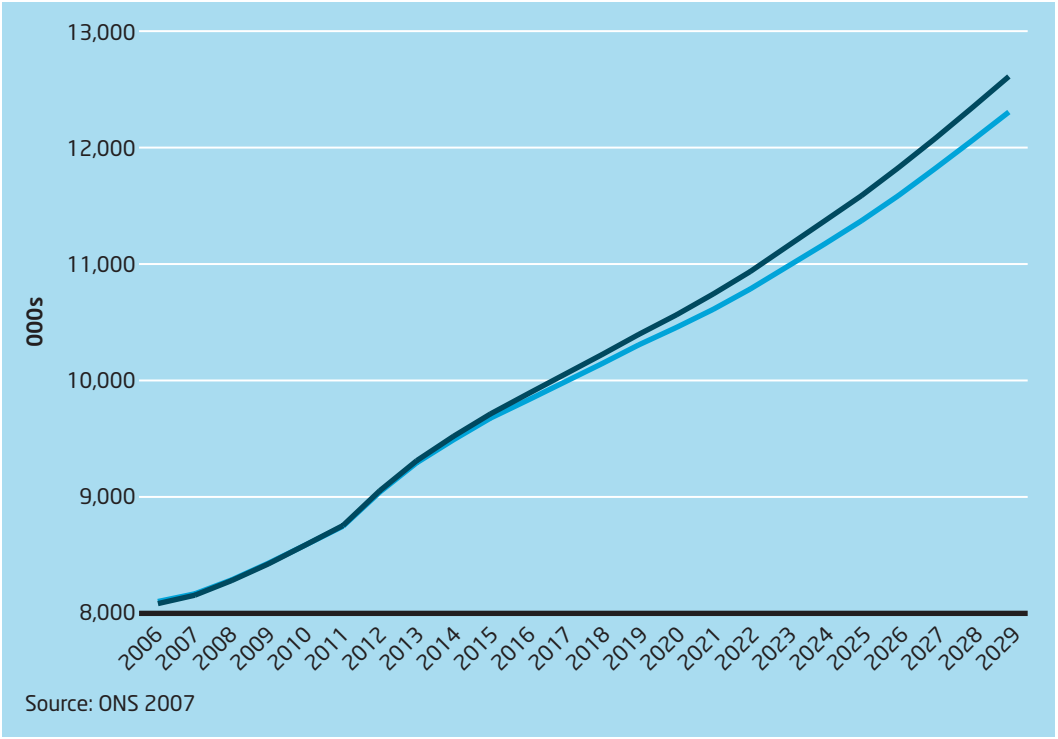


Figure 2 Projected growth in population aged 85 years+, 2006–2029

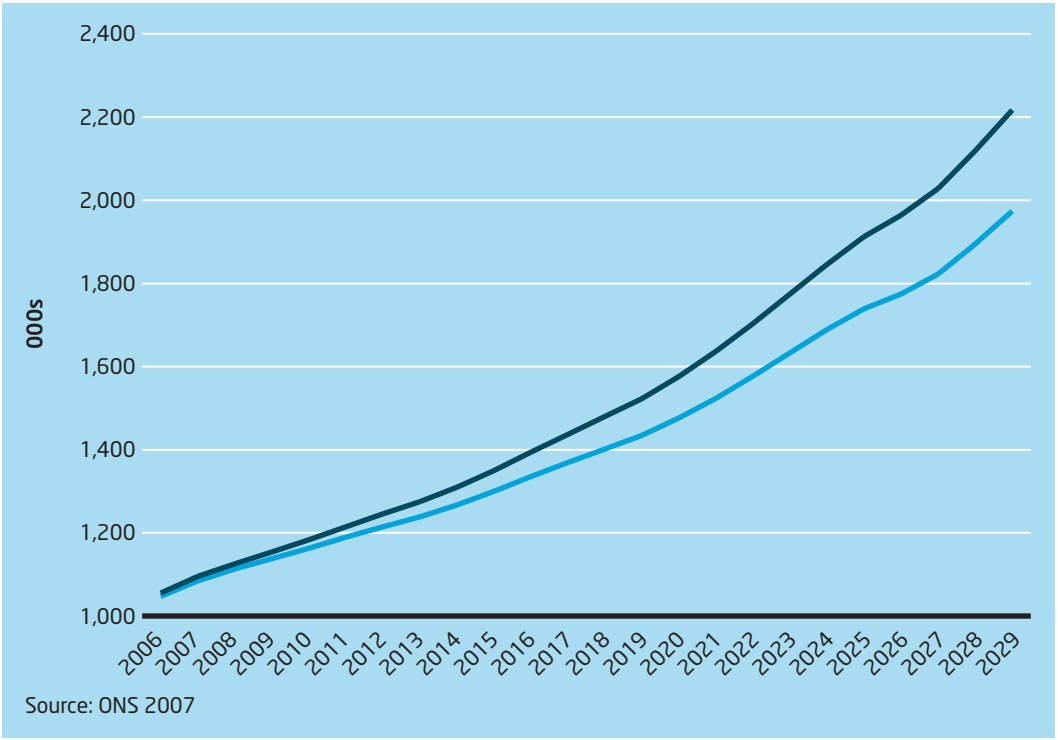
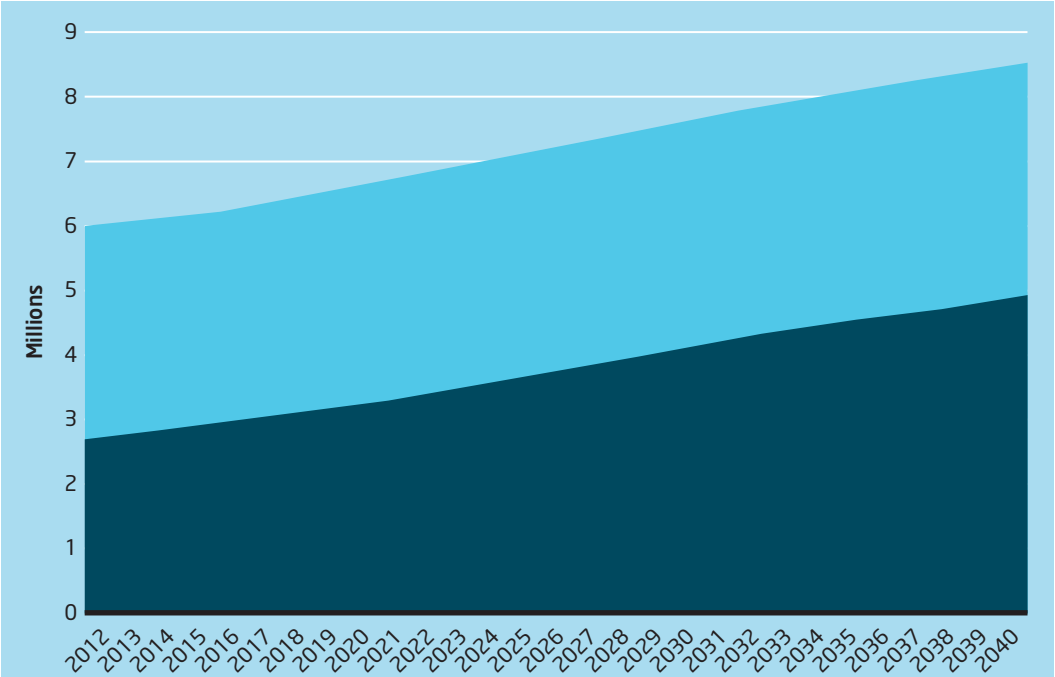


Figure 3 Projected number of adults aged 18+ with a care need in England, 2012–2040



Source: ONS 2007

A colder financial climate

Global economic recession, the near collapse of the banking sector and its impact on public debt, has transformed the economic and financial climate for all public services since *Securing Good Care for Older People* (Wanless 2006) was published.

Even before the recession, the government was predicting a £6 billion funding gap for social care by 2026 (HM Government 2009b). Councils are experiencing rising service demand and costs and falling income; charities/third sector organisations are describing a 'perfect storm' of falling donations and reduced investment income; independent sector providers too are vulnerable to rising costs and reduced access to capital.

In the meantime, if social care spending were limited to the 0.7 per cent real-terms increase in overall public spending envisaged in the 2009 budget report (HM Treasury 2009), this is likely to mean significant real-term cuts, especially when demographic and service demand pressures are taken into account.

Modelling work suggests that the current social care system for older people alone would need real-term funding increases of a minimum of 3.2 per cent per year in order to maintain the levels of support provided currently. Without productivity gains, this could increase to 3.7 per cent in real terms per year (HM Government 2009b). The projections we set out later in this paper suggest this could be higher still (*see* Section 3, pp 16–31).

The deterioration in the state of public finances over the last two years makes the task of reforming the funding of social care immensely difficult but underscores the necessity for change in view of escalating levels of need. The Green Paper *Shaping the Future of Care Together* (HM Government 2009b) has pointed out that HM Treasury's long-term

fiscal projections show that the costs of long-term care are set to increase by 17 per cent by 2027/8. The Department for Work and Pensions forecasts that in 20 years the cost of disability benefits could increase by almost 50 per cent (the figure is for benefits for the over-65s only, and for England, Scotland and Wales) (Department for Work and Pensions cited by HM Government 2009b). Doing nothing is not a cost-free option.

New ideas on funding options

The publication of the 2006 review stimulated new ideas about how care could be funded; it fostered a better understanding of different policy mechanisms, their costs, outcomes and distributional (who benefits and who loses) effects.

Shortly afterwards, the Joseph Rowntree Foundation (JRF) proposed a system that would combine a universal national entitlement with private contributions and remove means testing; it recommended a transparent co-payment arrangement whereby care costs would be split 80:20 between the state and individuals, similar to the partnership model of the 2006 review (Hirsch 2006).

Some of the most significant areas of new policy thinking about how individuals could contribute to the cost of their care has been fuelled by a growing awareness of the relative affluence of the newly retiring baby-boomer generation and the extent of housing wealth owned by older people. In 2006 older households (aged 60 years and over) were estimated to own £1,000 billion in housing equity, a sum projected to rise to £1.4 trillion by 2026 (assuming no real terms increase in house prices) or £2 trillion (assuming house prices rise by 2.5 per cent per year) (Holmans 2008).

The sheer scale of the sums involved, coupled with a colder financial climate and declining dependency ratios, have inevitably focused attention on housing wealth. It is a potential source from which care funding can be drawn, but also has implications for the so-called intergenerational contract – the broad consensus about how costs and benefits are distributed between working-age people and retired people. This is not simply a matter of the technical merits of different mechanisms. It fundamentally challenges traditional progressive assumptions about universal services funded through general taxation. This is succinctly put by James Lloyd:

> *These trends create serious problems for the equity and fairness of models of taxation-funded universal free care for older people. The implementation of this model of long-term care funding would see by far the richest cohort in history becoming the first to receive universal free care. This would be paid for, to a significant extent, by the most indebted cohort in modern times, who had in fact already transferred much of their current and future income and wealth to these older cohorts through the property market.*
>
> (Lloyd 2008)

How this large reservoir of housing wealth can be accessed to fund care has given rise to fresh consideration of existing products from the financial services industry that enable people to make provision for their own care costs. These include equity release, long-term care insurance, immediate needs annuities, and long-term savings plans. The take-up of most of these products has been relatively low, due to a varying mixture of high cost, public mistrust, lack of information and other market failures. But new ideas have emerged as to how, with state involvement and support, they could become more affordable, appropriate and effective as part of the solution towards meeting the future costs of care.

> *Taken together, concerted industry and state action could provide a comprehensive range of product options that co-exist and complement each other and enable individuals with different care needs, resources, attitudes to risk and inclinations to plan to approach long-term care in a way that best suits them.*
>
> (Resolution Foundation 2008)

This has opened up new possibilities whereby funding solutions could be co-produced by the state and the financial services industry. One example is the state establishing its own insurance scheme, such as the National Care Fund, a non-mandatory social insurance scheme to pay for the long-term care of older people, proposed by the International Longevity Centre (Lloyd 2008). Participants would make a means-tested one-off contribution and would then be entitled to a standard package of care paid for by the fund. Payment could be deferred until after death and funded from an individual's estate.

Finally, while much of the new policy thinking that has emerged since the 2006 review has been concerned with long-term reform, there have been important proposals for short-term measures to combat the worst excesses of the current system which should not be overlooked. For example JRF has proposed immediate steps that could include introducing an equity release scheme based on deferred payments, raising the capital limits for care home fees to £42,500 and doubling the personal allowance for council-funded residents in care homes (Collins 2009).

Some, but not at all, of this thinking has influenced the content of the government's ideas for reform as set out in the Green Paper *Shaping the Future of Care Together* (HM Government 2009a).

This announced the proposal to establish a new national care service that would be simple, fair and affordable. One of the funding options (*see* box opposite) is a variant of the original Wanless partnership proposal, whereby everyone would be entitled to have a set proportion of their care costs met by the state, but without the additional match-funding element that featured in the original proposals. Two of the original five funding options were excluded from subsequent consultation: the 'pay as you go' whereby individuals are wholly responsible for meeting the costs of their care with no state contribution was dismissed because many would not be able to afford to pay for their care; and free personal care funded through taxation was rejected on the grounds that it would place too much of a financial burden on the working population. With dependency ratios set to fall to 3:1 by 2029 (Office for National Statistics 2006), this argument has some credibility. However, as we will see, the costs of an unreformed system will continue to grow – a 'no-cost' option does not exist and the decision to completely rule out a wholly tax-based option has attracted criticism.

However, the position on free personal care appears to have shifted following a pledge by the prime minister at the 2009 Labour Party conference that people with the highest needs will be offered free personal care in their own homes. This is reflected in the Personal Care at Home Bill now before Parliament. Subject to the legislative process the government expects 'that this policy… will be implemented in October 2010' (HM Government 2009a) and is consulting on the guidance and regulations (Department of Health 2009b). The measure has been described as a stepping stone towards a national care service, with wider proposals expected in a White Paper in March 2010.

A further development has been the announcement by the Conservative Party of its intention, if elected, to introduce a 'home protection scheme' – a voluntary insurance

scheme whereby people can opt to pay a single premium on retirement, estimated at £8,000, in return for a guarantee that any residential care fees would be waived (Conservative Party 2009). It seems likely that this will form part of a wider series of reforms that will address the funding of care at home.

The funding options proposed in the Green Paper

1 Partnership In this system, everyone who qualified for care and support would be entitled to have a set proportion – for example, a quarter or a third – of their basic care and support costs paid for by the state. People who were less well-off would have more care paid for – for example, two-thirds – while the least well-off people would continue to get all their care for free. A 65-year-old in England will need care that costs on average £30,000 during their retirement, so someone who got the basic offer of a quarter or a third might need to pay around £22,500 or £20,000. Many people would pay much less. Some people who needed high levels of care and support would pay far more, and would need to spend their savings and the value of their homes. This system would apply to people of all ages.

2 Insurance In this system, everyone would be entitled to have a share of their care and support costs met, just as in the partnership model. But this system would go further to help people cover the additional costs of their care and support through insurance if they wanted to. The state could play different roles to enable this. It could work more closely with the private insurance market, so that people could receive a certain level of income should they need care. Or the state could create its own insurance scheme. If people decided to pay into the scheme, they would get all their basic care and support free. People could pay in several different ways, before or after retirement or after their death if they preferred. As an indication of the costs, people might need to pay around £20,000 to £25,000 to be protected under a scheme of this sort, compared with the average cost of care for a 65-year-old, which is £30,000. This system would work for people over retirement age.

3 Comprehensive In this system, everyone over retirement age who had the resources to do so would be required to pay into a state insurance scheme. Everyone who needed it would get all their basic care and support free. It would be possible to vary how much people had to pay according to what they could afford. The size of people's contribution could be set according to what savings or assets they had, so that the system was more affordable for people who were less well off.

Alternatively, if people wanted to be able to know exactly how much they would have to pay, most people (other than those with lower levels of savings or assets) could be required to pay a single, set figure. As an indication of the costs, people might need to pay around £17,000 to £20,000 to be protected under a scheme of this sort, compared with the average cost of care for a 65-year-old which is £30,000. The cost would be less for people who were over 65 when the scheme was introduced. People could pay in several different ways, in instalments or as a lump sum, before or after retirement, or after their death if they preferred. Once people had paid their contribution they would get their care free when they needed it. We would also look at having a free care system for people of working age alongside this.

(HM Government 2009b)

Lessons from other countries

Further insights into different policy approaches have emerged from abroad, and from closer to home in Scotland and Wales whose devolved administrations are pursuing paths that diverge significantly from the main options under discussion in England.

The decision of the Scottish Executive to offer free personal and nursing care (FPNC) marked a distinctive departure from the rest of the UK, this option having been proposed by the 1999 Royal Commission *With Respect to Old Age* (Royal Commission 1999) but rejected for England by the government as being unaffordable. Its operation since 2002 has now been evaluated (Sutherland 2008; Audit Scotland 2009).

Lord Sutherland (2008) concluded that 'despite some practical difficulties in its formative years, the FPNC policy remains popular and has worked well in the largest part, delivering better outcomes for Scotland's older people'. But he went on to outline areas of concern, including:

- consistency of provision between different local authorities (noting that there were already wide variations before the new policy was implemented)
- inadequate funding, resulting in the use of waiting lists, and the use of differing eligibility criteria from one authority to the next
- continuing debate about specific issues such as food preparation
- the practical implications of the legal ruling in the Macphail case (Macphail 2007)
- allowances for residential care not being raised in line with inflation.

It is clear that the FPNC policy has not in itself resolved a growing funding shortfall, estimated to be £40 million; Lord Sutherland recommended that future demand and costs of care need regular re-modelling to take account of demographic change (which was faster than the architects of the policy had originally anticipated) and that FPNC should be seen as just one part of the wider provision and funding of services for older people.

As a recent review noted:

> *The relatively swift move from political debate to implementation led to difficult negotiations between central and local government around the anticipated costs of care. Local variations in the implementation of this policy may be serving to maintain or open up new inequalities between different parts of Scotland. For example, some local authorities use higher need thresholds to manage demand for services, while others make use of waiting lists both for assessment of need and to access the full range of services.*
>
> (McCormick *et al* 2009)

Looking further afield, international evidence suggests that England's current arrangements for social care also diverge widely from many other developed countries. As Glendinning and Bell observe, '... virtually no other country restricts access to publicly funded social care only to poorer people; moreover, recent reforms in countries as diverse as Austria, Germany and Japan have increased rather than decreased the universal nature of their social care provision' (Glendinning and Bell 2008).

A further distinguishing characteristic of the UK approach is the faultlines between delivery and financing of health care, social care and the benefits system, together producing a fragmentation that causes real difficulties for people whose needs straddle these separate systems.

Few countries appear to consider private insurance options (either as a standalone policy or in partnership with the state) as a means of addressing demographic and funding pressures, and a study of Germany, the Netherlands, Denmark, Japan, and Australia found that in none were individuals' assets or housing equity used to fund long-term care; Australian plans to draw on the housing equity of older people to fund nursing home care were dropped after major political opposition (Glendinning and Moran 2009).

Prevention and early intervention – emerging evidence

The 2006 review noted that prevention had become a stronger theme of policy for older people following the publication of the 2006 White Paper *Our Health, Our Care, Our Say: A new direction for community services* (Department of Health 2006), but the majority of resources continued to be directed towards those with higher levels of need and more expensive forms of care. It concluded that 'there is an urgent need to establish the cost-effectiveness of prevention and preventive services. There appears to be significant promise in this regard, but the evidence base is not yet sufficiently developed' (Wanless 2006).

Three years on, a clearer evidence base is beginning to emerge of the value of strategies based on prevention and early intervention, including the growing use of telecare, intermediate care and re-ablement services, falls prevention and early intervention strategies such as casefinding and the use of predictive tools to identify individuals at high risk of emergency care (Department of Health 2009c). The Partnerships for Older People pilot projects are beginning to show how these approaches can achieve better outcomes for individuals (for example, by promoting independence and enabling people to continue to live in their own homes) and achieve better use of resources across health and social care systems (for example, by preventing admissions to hospital or the need for long-term care) (Personal Social Services Research Unit 2010). That they may also produce capacity gains in acute hospitals reinforces the need to consider how social care and NHS resources can be better aligned locally. Prevention is not just about older people. Re-ablement and rehabilitation services are vital to younger people who have acquired physical and sensory disabilities. Access to work opportunities for working-age people with disabilities can help to promote independence and social inclusion (Department of Health 2009d).

Improved modelling tools

The analytical tools used to make assessments of funding options have been developed and improved since the 2006 review. The original assumptions in the analysis have now been subject to debate and challenge and have been revised where relevant. In the next section we use this modelling to examine the implications of funding and service reform, including a more detailed breakdown of costs, recipient numbers, and implications for levels of unmet need, on the rate at which people have to draw on their savings, and whether they are net beneficiaries financially from any change.

3 The funding options assessed

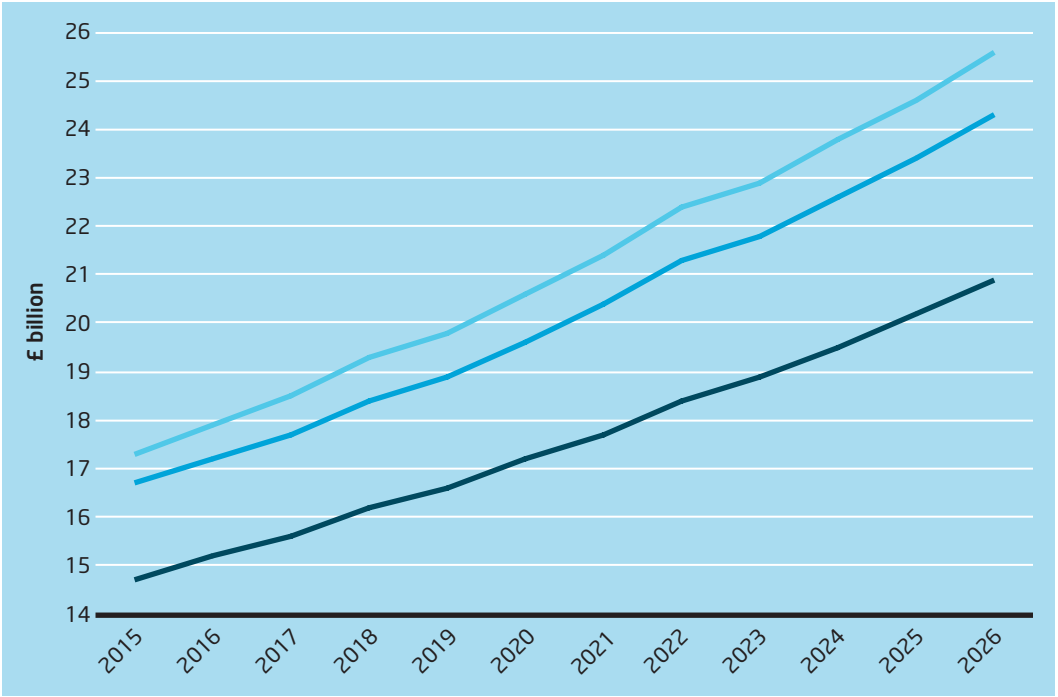
Key points

- The projected costs of social care for older people (using 2007 prices) for each of the options modelled are set out in Figure 7, p 21. In summary:
  - the existing system, based on current levels of support, is projected to cost just over £8.1 billion in 2015, rising to £12.1 billion by 2026 – a 50 per cent increase
  - The King's Fund partnership model (Partnership50% – a 50 per cent guaranteed package and a £1 matching contribution for every £2 individuals pay themselves and a relatively generous income support supplement) is projected to cost £10.1 billion in 2015, rising to £15.5 billion by 2026 – 90 per cent more than the existing system would cost in 2015
  - free personal care (FPC) is, unsurprisingly, the highest cost model, at £10.7 billion in 2015 rising to £16.8 billion by 2026 – an increase of just under 110 per cent.
- Both the partnership and FPC options would offer a much more universal system of support than the existing system – almost two-thirds more people would receive public funding; but the much higher cost of FPC does not significantly increase the number of recipients.
- Turning to the impact on **outcomes**, whereas an unreformed system would see unmet need continue to rise, the Partnership50% model would halve the amount of unmet need compared to the existing system in 2015 – and free personal care would reduce it still further (*see* Figure 11, p 27)
  - The other potential source of unmet need is the system failing to offer enough care to those who are eligible for support. The 'benchmark' care packages recommended by the 2006 review work on a cost-effectiveness principle and in most cases result in a higher care 'offer' for people – a 35 per cent extra cost to the state (in 2014/15) (ie, £13.6 billion a year for Partnership50% (a 50 per cent guarantee level and a £1 matching contribution for every £2 individuals pay themselves) and £10.9 billion a year for the existing system) would buy a 40 per cent reduction in unmet need.
  - However the costs of offering this higher level of support would escalate sharply for older people, requiring a 104 per cent increase by 2026 or, if the Partnership50% were adopted, a 163 per cent increase. Whatever funding system is adopted, it is clear that the costs of meeting unmet needs will pose a greater challenge than the costs of demography alone.
  - The extent to which people have to draw on their savings and assets to pay for care is greatest under the existing means-tested system, especially for residential care and for people with relatively modest means. By contrast, the partnership model helps these people significantly (*see* Appendix Table A14, p 53). Use of savings is lowest under free personal care because charging is minimal (*see* Appendix Table A22, p 59).

– Examining the total lifetime net benefit (the value of care people receive less the charge they pay) makes it possible to assess '**winners and losers**' from a change to a different funding system. This suggests that people would be slightly better off under the free personal care than partnership model. However, very well-off people with high needs will gain significantly, whereas poorer groups gain by a more modest amount. This reflects the generosity of free personal care in which the state covers all personal care costs, irrespective of income or wealth.
– In short, implementing a universal system will reduce unmet need by reducing the cost of care for people who are currently self-payers. This effect is expected to be relatively small for the very rich who can afford care costs and are not put off in their care purchasing decisions. For the moderately wealthy, ie, those just above the current asset limit (£23,000), this effect could be significant. The partnership model, in scaling its support along wealth lines, helps this moderate wealth group more than the very rich. Free personal care would help both groups, with the richest benefiting the most.

- For working-age adults public spend on social care is projected to need more than £6 billion in 2014/15, rising to just under £9 billion in 2025/6. However, these figures are based on current levels of support, and more work is needed to develop the costs of higher levels of benchmark support similar to that for older people. Subject to this caveat, these projections can be added to those for older people to give a picture of the total public cost of social care for all adults in Figure 4, below. Although it seems likely that working-age people will continue to receive care and support free at the point of care, it raises questions about the overall amount of additional public funding required to meet growing needs and expectations, and the dangers of a system that is separate from that of older people.
- Most of the options considered in this report are more expensive than the current system, but produce better outcomes overall.

Figure 4 Public spend on social care for all adults, 2015–2026



Introduction

The complex nature of care and support and its funding makes a simple solution unlikely. In this section we build on the original analytical work carried out in the 2006 review to assess the detailed implications of reform options using a micro-simulation approach. This work will give us a better understanding of the nuanced implications of changes in the way care is funded.

This section

- updates the analyses carried out by The King's Fund 2006 review (Wanless 2006), providing updated estimates of costs and benefits to the state and private individuals of implementing a universal partnership funding model
- summarises the projected costs of the free personal care (FPC) option, as well as the projected costs of the existing system unreformed
- sets out for each option
  - the aggregate costs of the system broken down by payer and type
  - the costs of transition arrangements
  - the numbers of recipients in each system, by type
  - the impact of the system on unmet need levels
  - the affordability implications (in terms of how much people must draw on their wealth)
  - an analysis of winners and losers.

An analysis of the comprehensive and voluntary insurance options set out in the Green Paper *Shaping the Future of Care Together* (HM Government 2009b) has not been included as the details underpinning these models have yet to be published by the Department of Health. Nonetheless it is clear that the Green Paper partnership model is similar to the Wanless partnership model, the main differences being that it is less generous and would not match private contributions with further state contributions. Similarly, the proposals for a comprehensive model in the Green Paper echo those of a free personal care arrangement, but with part of the additional funding of that model being recouped from a dedicated social insurance contribution rather than additional general taxation funding.

This section concentrates mainly on how different funding systems affect older people. The main reason is that older people pay a far higher proportion of their care from income and assets directly (as well as indirectly through taxation) than younger adults pay. Younger adults, supported through local authorities, have more than 95 per cent of their care costs covered by the public system. Changes in the funding system therefore have relatively little effect on the amount of public spending for younger adult user groups. The cost implications for younger adults and the need for further work in this area are briefly outlined. In conclusion the projected costs of each option for all ages are set out.

Costs have been modelled for the period 2015–2026. Although a White Paper on funding reform has been promised, the lack of current political consensus suggests there will be little substantial change in overall funding models before 2015.

The existing system

The projected costs of the existing, means-tested system offer a baseline against which the costs of other funding models and options can be compared. It shows that even without reform the cost of the existing system to the public purse would nearly double

by 2026 – from £6.3 billion to £12.1 billion (*see* Appendix Table A3, p 46). The contribution of individuals to their care would more than double, from £6.7 billion to £14 billion. Total public and private spend would rise from £13 billion to £26 billion. The costs of Attendance Allowance would increase from £3.7 billion to £5.1 billion. By 2026, 53 per cent of the total costs of care would fall on the state, excluding Attendance Allowance, and 46 per cent would be met by individuals.

The King's Fund partnership model

The original partnership model put forward in the 2006 review offered a universal, free-of-charge minimum guaranteed amount of care – set at 66 per cent of the total assessed care package (which varies according to need). Individuals could then make contributions matched by the state (up to the cost of the assessed care package): in the model, every pound that people contribute is matched by a pound from the state until 100 per cent of the cost of the normative (standard) care package is achieved (or until individuals decide not to consume more care). Thereafter, extra private contributions are not matched by the state. Importantly, the partnership proposals include an income support component to help those on low incomes to make additional contributions through the benefits system. This component of the proposals could be implemented through Pension Credit in the social security system and/or could be part of the care system. The advantage with the former is that it would take the task of means-testing individuals out of the care system. As a shorthand, this benefit is hereafter described as the *partnership benefit*. The amount of this benefit is calculated through the Pension Credit system. It ensures that people have enough income beyond everyday living costs to cover charges for care in the partnership system. Living costs are set to equal 125 per cent of the minimum income guarantee level in Pension Credit.

Figure 5, overleaf, summarises the sharing of care costs between the state and individuals (excluding the pension credit element). It shows that where individuals choose to receive the assessed level of care, the state contributes 83 per cent of the cost of care (66 per cent of which through the guaranteed element and 17 per cent through the matched element) and individuals pay 17 per cent of care costs. Those on low incomes would get additional support to help them pay the 17 per cent (which could still be a quite sizeable amount if their needs were significant).

The original partnership model (and also the free personal care model) required more public expenditure than the current means-testing system but both would deliver better outcomes. A central consideration in the adoption of any new funding system rests with society's willingness to pay for better outcomes for the in-need older population. At the time of the 2006 review the state of public finances was markedly better than the situation in 2009/10. Given the substantial extra funding that was being found for the NHS at this time, it was felt that an appetite existed for additional funding of social care. As of 2009/10 this aspiration appears overly optimistic. The partnership model is, nonetheless, adjustable and can be configured to place lower additional demands upon the public purse (however with a corresponding reduction in the scale of improvements in outcomes). We have therefore modelled in this report a modified version of the partnership model with a 50 per cent guarantee level and a £1 matching contribution for every £2 individuals pay themselves. We refer to this as the Partnership50% model (Figure 6, overleaf). This compares to the original 2006 review model with its 66 per cent guarantee and £1 for £1 match funding.

Figure 5 The original partnership funding model

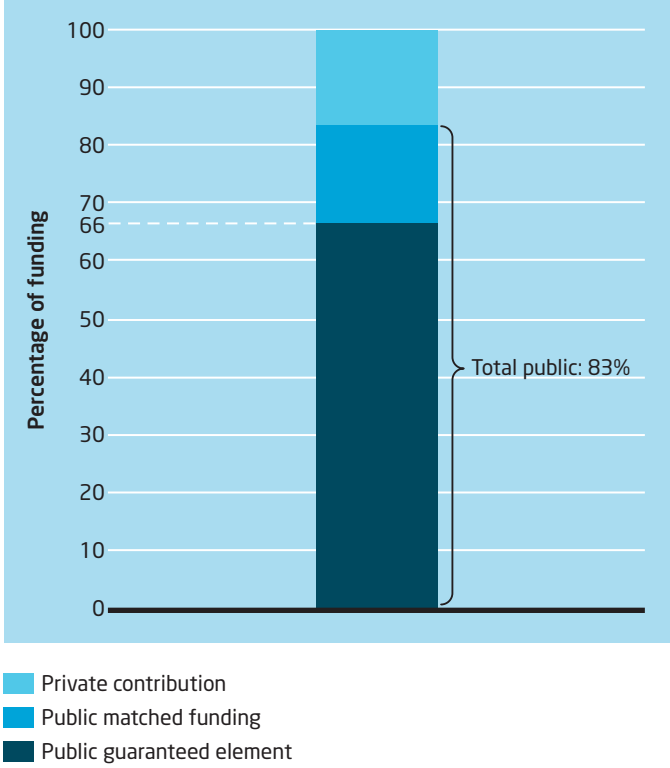
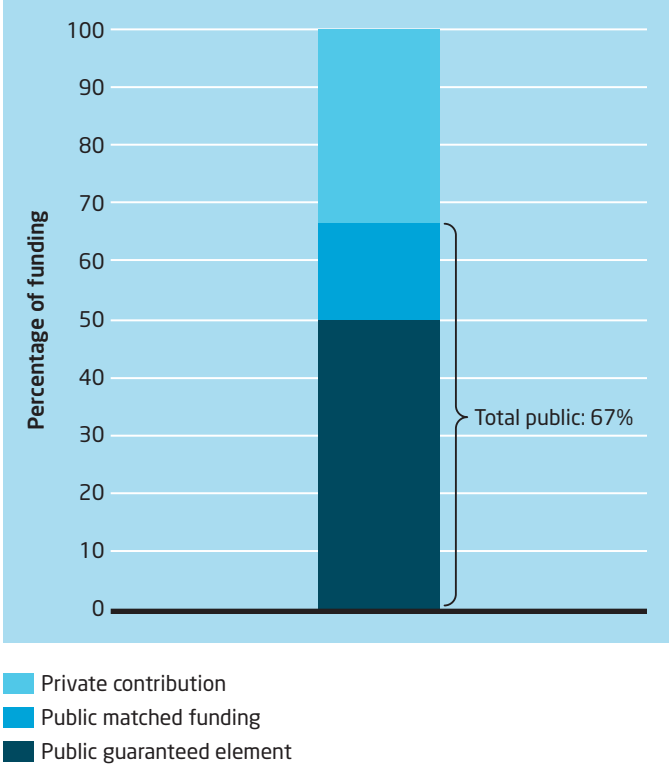


Figure 6 The Partnership50% model



The partnership model – costs

The Partnership50% model would see the net public spend on social care rise from £10.1 billion in 2014/15 to £15.5 billion by 2025/6 (*see* Figure 7, opposite). Private spend would rise from £8.3 billion to £14.8 billion, and total public and private spend would reach £30.3 billion in 2026 compared to £18.5 billion in 2015 (*see* Appendix Table A4, p 46).

Relative to the current means-tested system, the increased involvement of the state in the funding of social care for Partnership50% means there would be less need for people to self-fund their care. In particular, the universality of state support means that almost all people needing social care would be covered by the partnership scheme. Most non-scheme use of social care would be by people with lower levels of need – mostly domiciliary care. Although some people with lower levels of need would enter residential care outside the scheme (that is, they fund their own care), the numbers would be extremely small. So more people are supported to stay in their own homes and remain independent.

Under the partnership proposals, a high proportion of care and support expenditure – 55 per cent of the total cost in 2015 – would be funded by the state. Over time, social care expenditure is predicted to increase at a faster rate than expenditure on disability benefits. This is due to the fact that whereas the unit costs of social care services increase above general inflation rates, social security disability benefits are indexed against general inflation.

To illustrate the impact of altering the guaranteed level of state-funded care, the costs of a more generous 66 per cent state funding and a matching rate of £1 to £1 (consistent with the original assumptions of the 2006 review) would be £10.7 billion in 2015, some £0.6 billion more than the 50 per cent guarantee version (*see* Appendix Table A5, p 47).

Figure 7 Public spend on social care for older people, 2015–2026

The difference in cost is perhaps less than expected. However, by 2026 the 66 per cent level would add over £1 billion to the public cost of care compared to the 50 per cent level. Increasing the guarantee and matching rates generates lower charges for individuals, but as a result people's eligibility for the *partnership benefit* decreases. As outlined above, this benefit provides additional income so that poorer people can afford partnership model charges. As charges decrease, so this benefit decreases.

The partnership model – with increased support

Concerns about the level of unmet need led the 2006 review to recommend a significant increase in the levels of support offered to people with care needs. Since then, resources have been concentrated even further on those with highest needs – unmet need has therefore grown. In a reformed system, many people whose needs fall outside of the current eligibility criteria would be offered support – all people with moderate need and above (compared to only a third with moderate needs under the current system). Further details can be found in Appendix 1, pp 42–60. The benchmark care packages used in the 2006 review were calculated on the basis of conservative estimates of value for money of social care outcomes achieved by the support system. These benchmark levels of care enable us to estimate the costs of addressing unmet need – a major area of weakness and dissatisfaction with the current system.

Implementing a partnership model with benchmark levels of care rather than current levels of care increases both costs and benefits. It would add £3.5 billion to public spend on social care in 2015. Applying benchmark levels to the existing system would add £2.8 billion – less than the partnership option because fewer people fall within the public system under means testing.

The net public cost of moving from the projected cost of the existing system (with current packages of care) to Partnership50% with benchmark packages is therefore £5.5 billion in 2015 (£3.5 billion of this accounted for by moving from current levels of support to benchmark care and £2 billion accounted for by moving from the current system to Partnership50%, under which more people would be covered).

The partnership model – numbers of people helped

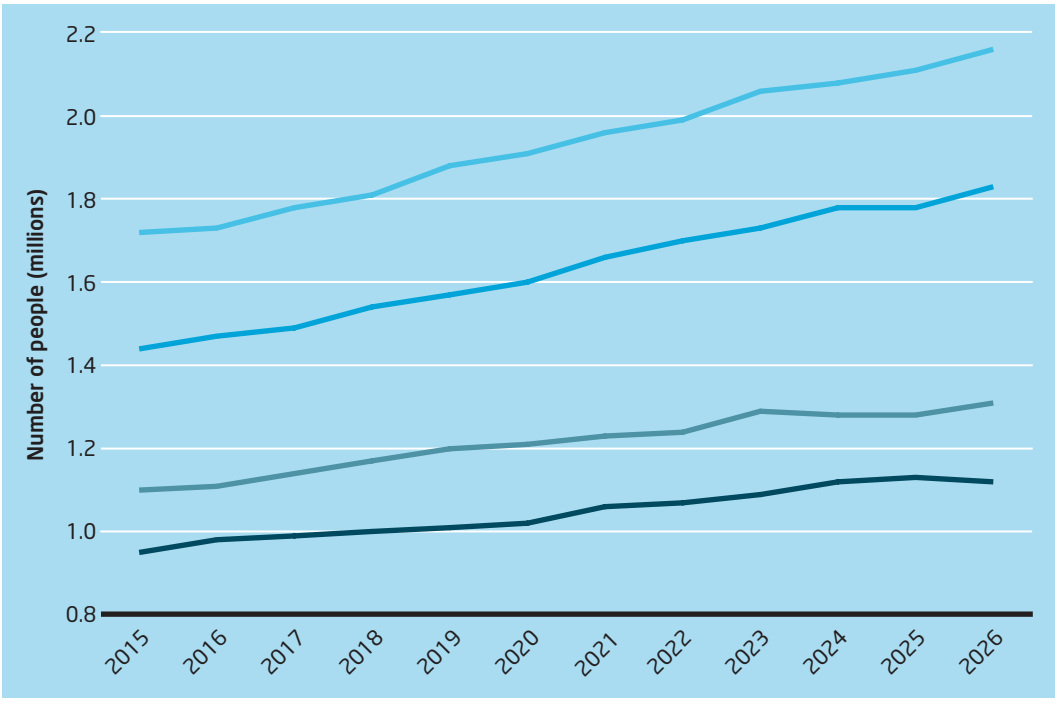
The number of people receiving public funding towards the cost of their care varies according to the funding option selected, as Figure 8, below, shows. Adopting a partnership model would substantially increase the number of people receiving publicly funded support – by more than 800,000, or 63 per cent more than under the current funding system; if higher benchmark levels of care were provided, almost twice as many people would become eligible for public funding.

This expanded coverage explains much of the higher cost of the partnership model compared to the current system with its higher levels of unmet need. More people are helped under a reformed system. If higher benchmark levels of support are offered, even more people receive help.

The 'safety net' nature of the current system ensures that the number of people helped will always be significantly lower than any of the options considered here, even if benchmark levels of care are provided (*see* Appendix Tables A10 and A11, pp 49–50).

Under the existing means-tested system anyone with eligible assets of more than £23,000 (currently) faces the full costs of care. Furthermore, because these costs can be very high, some people defer or delay seeking formal care and either manage on their own or seek help from family and friends.

Figure 8 Number of people receiving help under different models, 2015–2026



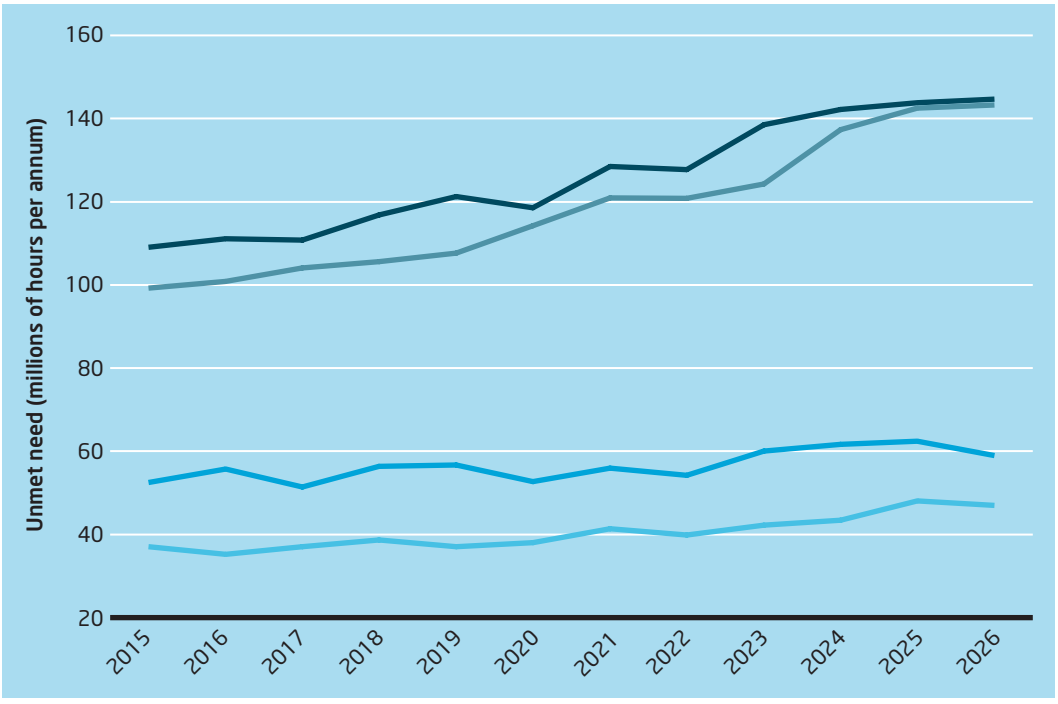
Although Partnership50% would be a universal system, a number of people are projected to buy care privately (these are described in the tables as non-scheme recipients). This may be because their needs are below the eligibility level or because some people simply don't seek formal support. All of the funding options considered here assume that a proportion of people will never seek care, preferring to rely on family or informal support – although that decision is partly based on the level of help provided by the public system.

The partnership model – outcomes

The evaluation of any funding option should examine not only the implications for costs and expenditure but also the impact on outcomes for people with care and support needs. Two aspects are of particular relevance – the impact on the level of needs met by care services, and the impact on the amount of resources that private individuals need to contribute (and how these contributions might erode savings and other assets). It is also useful to examine the impact of the reforms compared to the current system and to look at the characteristics (for example need and wealth) of the people who would win or lose in terms of the amount of care received and financial contributions made following the implementation of the reforms.

Levels of unmet need, measured in millions of hours per annum, would be much lower under the partnership model as Figure 9, below, shows. Practically all people with eligible needs (moderate or above) are covered under partnership, and all people get at least the guaranteed package of 50 per cent of the total. Most people also pay into the scheme to benefit from the matched contribution. Applying higher benchmark levels of support would reduce further the amount of unmet need under both systems.

Figure 9 Partnership model – unmet need including informal care



The partnership model – savings and assets

Another major concern about the current system is the extent to which people are required to draw on their assets to pay for care especially when they are relatively modest. So an important criterion in judging alternative funding systems is how they impact on people's ability to pay, and, in particular, the degree to which people can pay care charges out of income or whether they have to draw on their assets. This is a particular concern for people who need residential care for a longer period that could cost hundreds of thousands of pounds, and who are not currently entitled to public funding because they have more than £23,000 in savings and assets.

For people assessed as needing residential care and not entitled to public funding, use of savings to pay for care would be significantly lower under the partnership model – just under £22,000 compared to nearly £28,000 under the current means-tested system. This will be explored further when we examine free personal care.

The partnership model – winners and losers

At a societal, aggregate level, the costs and care benefits of any funding model are perfectly offset, in the sense that the costs of the system equal the cost of funding the care that is provided. At the individual level, however, different funding systems distribute differently the responsibility to fund care and the receipt of support across socio-economic and need groups. We can assess how much people benefit from the care system, in terms of the value of care they receive from the scheme (in £s per week) less the amount that they have to pay in charges, over the person's lifetime. This total lifetime net benefit is significantly higher under the partnership option as Table 2, below, shows – as would be expected given that the net public spend is higher under this option.

Table 2 Total lifetime net benefit (mean)

	Partnership50%		Means testing	
	Residential	Non-residential	Residential	Non-residential
Not MT entitled	£26,560	£6,490	£19,360	£2,890
MT entitled	£56,800	£17,890	£56,770	£16,400
All	£44,830	£13,380	£41,960	£11,050

We can also consider who benefits and who loses. Overall, it is clear that the vast majority of people, with either high or low needs, are no worse off and often significantly better off under partnership. For the very few people who are worse off, the average loss per week compared to what they would benefit from under means testing is relatively small.

The original partnership model was designed to be particularly beneficial to those people needing residential care – that is, the highest need, most vulnerable groups. As shown in the previous section, the means-tested model can produce very high levels of savings and asset spending for people in residential care who are not eligible for state support, forcing many to sell their homes. By contrast, the partnership model helps these people significantly. Everyone needing residential care would be better off under the partnership option than under the existing means-tested system, as Table 3, opposite, shows. The partnership system therefore plays an important 'insurance' role, in moderating the financial risk associated with the need for social care, and in particular for residential care.

Table 3 Partnership50%: winners and losers – residential care

Need		Wealth quintiles				
		Poor	Moderately poor	Moderate	Well-off	Very well-off
High	Worse off (%)	0	0	0	0	0
	Mean loss (£s/wk)	0	0	0	0	0
	Max loss (£s/wk)	0	0	0	0	0
	Better off (%)	100	100	100	100	100
	Mean gain (£s/wk)	7	13	25	31	78
	Max gain (£s/wk)	96	95	104	97	102

Free personal care model

Having considered the costs and outcomes of the partnership model, we now turn to free personal care, noting its similarities with the comprehensive option of the Green Paper *Shaping the Future of Care Together* (HM Government 2009b) which involves care free at the point of use funded mostly through taxation (albeit of a very specific kind).

The free personal care (FPC) model removes the financial means-test of the current system for the 'personal' care component of a person's care package, that is it is completely free at the point of use and is funded entirely through taxation (or other public funding such as social insurance). In some respect this system mirrors the arrangement in Scotland. Here the model is fine-tuned to be consistent with the situation in England. In particular, based on analysis of current expenditure data, we assume that 70 per cent of the current care package that people receive is personal care and would therefore be available without charge. The remaining 30 per cent of community care packages are means tested in exactly the same way as the current system. In other words, the scenario is compatible with a change in policy which would affect exclusively those care inputs defined as relating to support with personal activities of daily living (ADLs). Moreover, all hotel costs in care homes would continue to be means tested according to the current rules. Overall, therefore, a relatively small proportion of total expenditure actually falls under the 'personal care' definition in this model (it is important that this option does not mirror the current proposals for free personal care support, which only affect individuals with critical needs, problems with at least four ADLs and residing in the community).

This option is modelled on the basis of current care packages.

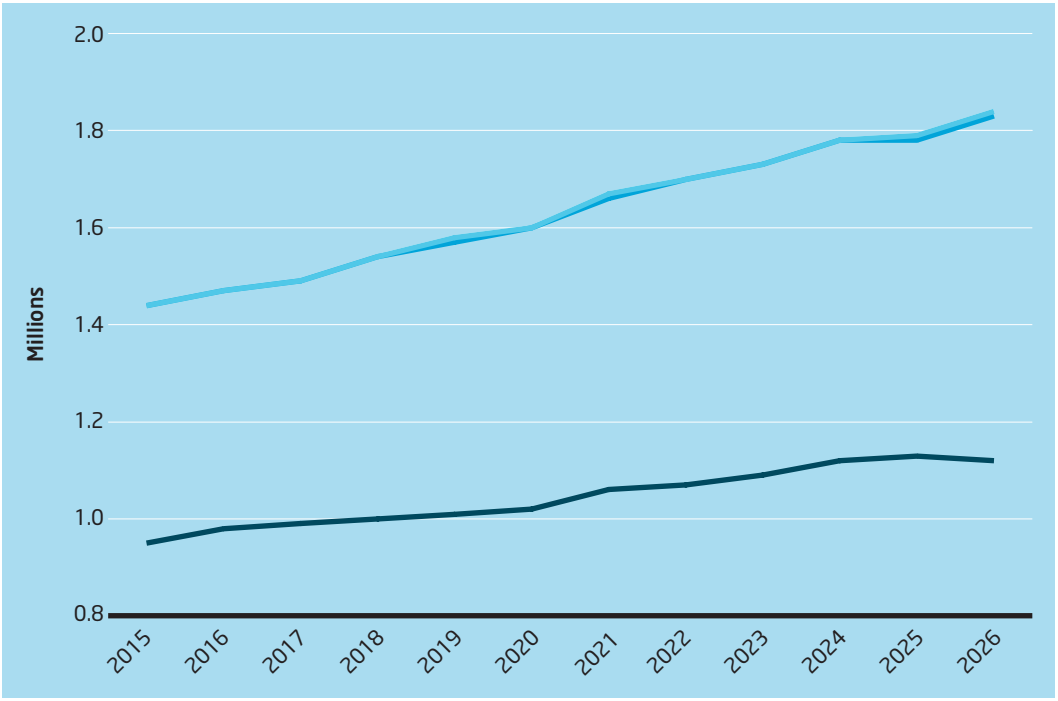
Free personal care – costs

The introduction of free personal care would see the net public spend on social care for older people rise from £10.7 billion in 2014/15 to £16.8 billion by 2025/6. Private spend would rise from £8.4 billion to £14.5 billion; total public and private spend would rise from £19 billion to £31.4 billion (*see* Appendix Table A19, p 58). These costs are higher than those of the existing system and the partnership options. A higher proportion of the total costs of care fall on the public purse – 56 per cent.

Free personal care – numbers of people helped

Most of the increased cost arises from the increase in the numbers of people entitled to free personal care (*see* Appendix Table A20, p 58). FPC would see substantially more people receiving publicly funded support – 64 per cent more than under the existing

Figure 10 Number of people receiving help, options compared, 2015–2026



system in 2026. Not surprisingly, however, due to the fact that both systems offer universal support, the numbers of recipients under FPC are practically the same as under the partnership option, as Figure 10, above, shows.

Free personal care – outcomes

The impact of the FPC model on unmet need can be assessed in exactly the same way as for the partnership model and the existing system (*see* Figure 11, opposite, and Appendix Table A21, p 59). The level of unmet need – just under 39 million hours in 2015 – is significantly below that of the existing system and slightly lower than the partnership option.

Free personal care – savings and assets

Spend-down of savings and assets would be lower under FPC than either the existing system or Partnership50% because charging is minimal (*see* Appendix Table A22, p 59) – the burden of costs shifts from the individual's savings and assets to the state. For people assessed as needing residential care and not entitled to public funding, spend-down would be just over £17,000 compared to just under £22,000 under the partnership model and nearly £28,000 under the current means-tested system.

Free personal care – winners and losers

Applying the same approach to identifying who would gain and lose from moving away from the current means-tested system, projections suggest that people would be very slightly better off under FPC over their lifetime than under Partnership50% (*see* Appendix Table A23, p 59). This is compared with the other funding options in Figure 12, opposite.

Figure 11 Free personal care – unmet need including informal care

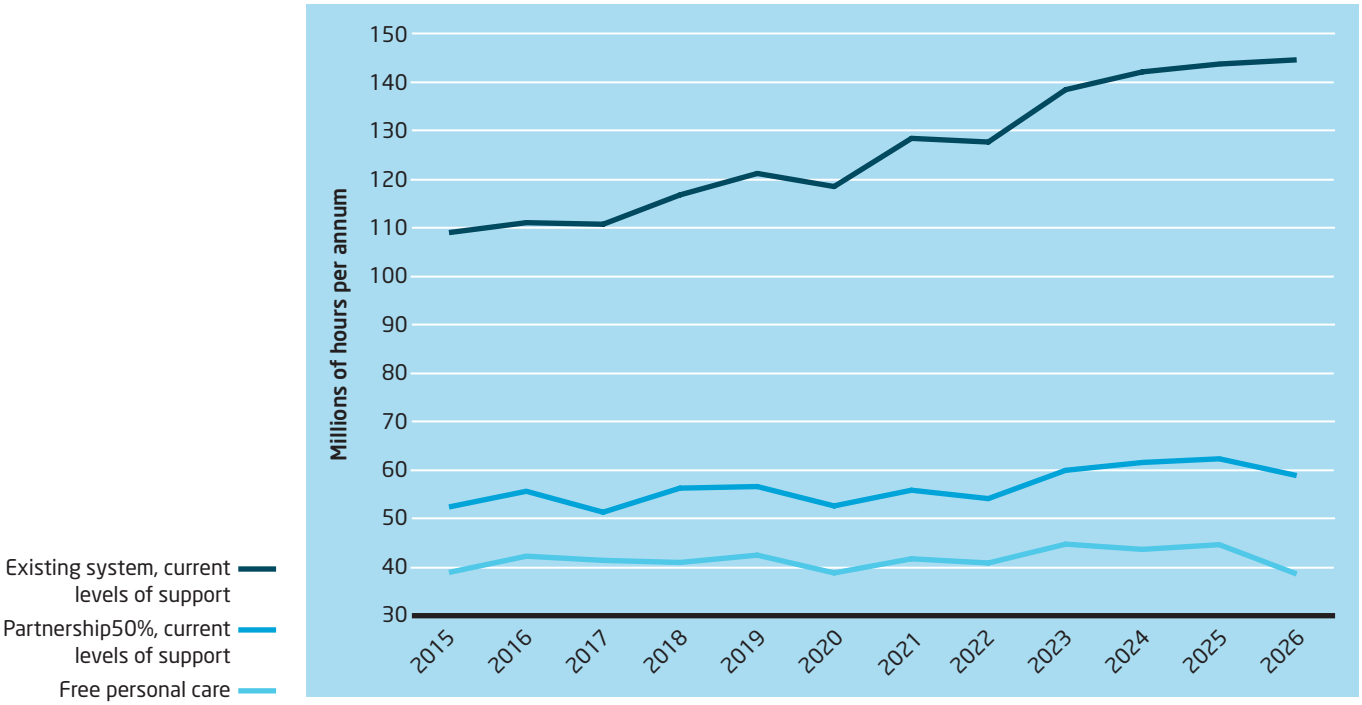
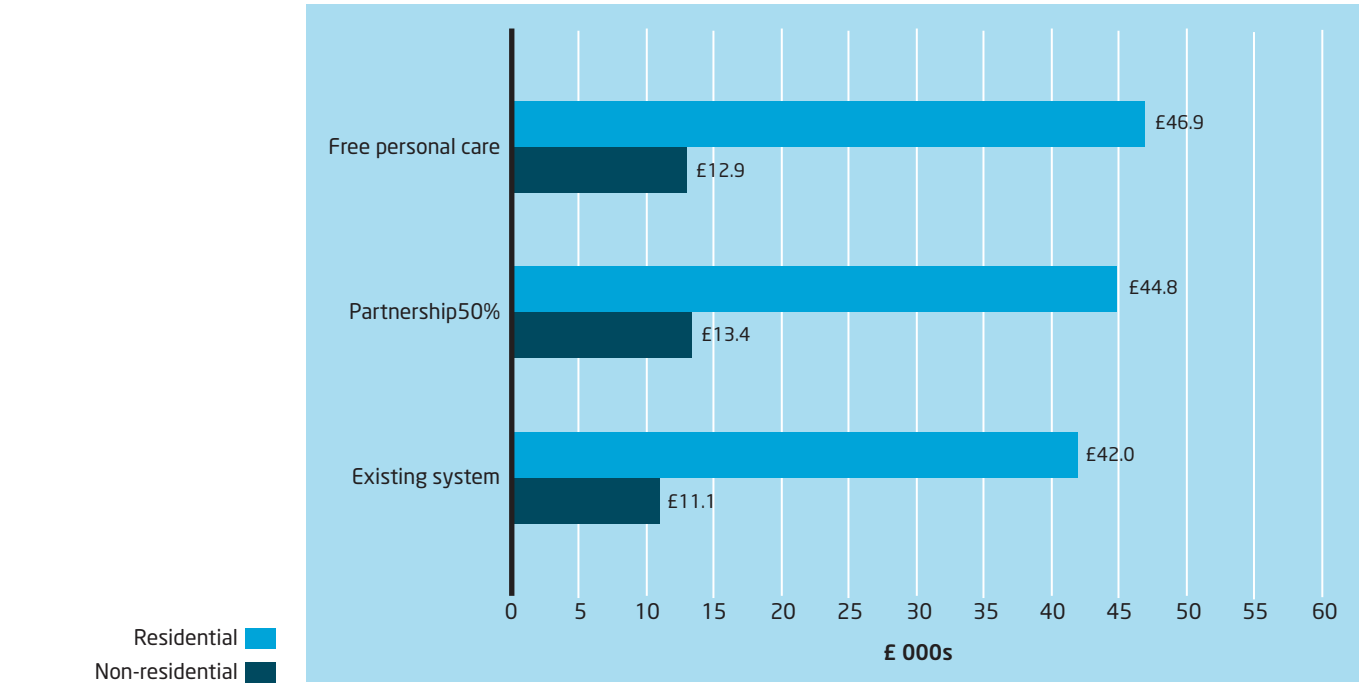


Figure 12 Total lifetime net benefit (mean)



Under the FPC model, people will be better off (or no worse off) because they pay nothing for their personal care and any other care they use would be chargeable on the basis of exactly the same financial means-test as under the existing system (*see* Appendix Table A24, p 60). Those who have high needs and are very well-off gain significantly on average, with poorer groups gaining by a more modest amount. This is one of the main differences between FPC and Partnership50%. The latter only provides partial state help for the richest whereas under FPC these groups have all their (personal) care costs covered by the state so benefit more than the less well-off.

One of the objections to implementing a more universal funding system rather than the current means-tested model is that the extra public resources required would simply be used to offset the spending on care of the wealthy. This was a particular objection made by the government against the implementation of FPC when recommended by the 1997 Royal Commission (reported in 1999). As we show with these analyses – and as was argued in the 2006 review – this is not the case. Part of the unmet need in the population occurs because moderately wealthy people who do not qualify for state support under the current system face high care costs as self-funders and may defer securing care. Moving to a more universal arrangement would lead to a reduction of unmet need. It would, nonetheless, disproportionately benefit wealthier people at the point of need. A balance needs to be struck between the contributions made to the funding of care by individuals and the state. The partnership model ensures that higher state support is provided to individuals with lower means.

The Green Paper options compared

The absence of detailed modelling data underpinning the Green Paper *Shaping the Future of Care Together* (HM Government 2009b) makes it impossible to assess its impact on costs and outcomes – including unmet need, spending of savings and assets, and 'gainers and losers' – in the same way. The King's Fund original partnership model can nevertheless help to illuminate the Green Paper's options, and to what extent they relate to the funding options that we have been able to model.

The partnership option put forward in the Green Paper shares the underlying principle of The King's Fund partnership model – that paying for care is a shared responsibility of the state and the individual, and represents a shift from the safety net approach of the existing system towards a more universal 'offer' in which everyone, regardless of wealth, receives some basic support for free from the state. This fits well with an approach based on a national entitlement and a move towards a national care service. However it differs from The King's Fund partnership model, and the revised Partnership50% model costed in this report, in two respects:

1. It is less generous, covering for some individuals no more than a third of total care costs compared with the 50 per cent proposed in our model. Clearly this would bring down the overall cost to the state, but also scale back the positive outcomes of the Partnership50% model. Fewer people would receive help and unmet need would be higher, as would the spending of savings and assets.
2. There is no matched-funding component whereby individual contributions are matched by financial contributions from the state. This is a significant omission, with implications for both the costs and outcomes of a reformed funding system. An advantage of the matched-funding arrangement – albeit a less generous one than proposed originally – is that it offers a means of 'nudging' people towards contributing to the costs of their care and support through the incentive of further state contributions. It addresses directly the perception that the current means-tested

system penalises those who have managed to save and accumulate modest means. It offers a mechanism to lever additional private contributions into an underfunded system. It is also flexible and the proportion of matched funding can be adjusted according to prevailing economic circumstances, reducing the need for major system change in the future.

Administering and tracking individual contribution as part of the matched-funding arrangement could be seen as complex to implement and maintain, but is no more so than many other types of user charges across public services, ranging from personal taxation to congestion zone charging. It would also involve far fewer people – less than 2 million by 2026.

The **insurance option** proposed in the Green Paper appears to work as an adjunct to the partnership model by offering people a means of insuring the cost of their own contributions, thus protecting their savings and assets. As a form of asset protection, it could be an attractive option to those with modest assets, depending on the amount of the premium. It has some similarities with the home protection scheme proposed by the Conservative Party, except that the latter covers residential care home fees only. A voluntary insurance arrangement would be consistent with the importance attached to choice across the whole spectrum of public policy, especially health and social care. The voluntary nature of the scheme, however, raises questions as to how much additional new money it would bring in to the care funding system, and about its distributional ('winners and losers') implications, since it would be likely to benefit mostly individuals with higher means whose capacity to purchase cover is greater. Voluntary insurance was rejected by the Royal Commission (1999) and has not developed in the private market.

The Green Paper's **comprehensive option** comes closest to a system that is funded largely through taxation and is free at the point of use – but for older people only. Everyone over retirement age would pay a means-tested amount into a compulsory state insurance scheme, in return for their care being fully funded. It is essentially a form of additional taxation, albeit in the guise of social insurance that is age-related and for a specific purpose. As with other Green Paper options, it is difficult to assess the costs and outcomes without underpinning data and much would depend on the nature of the means-testing arrangements on which the option appears to rely.

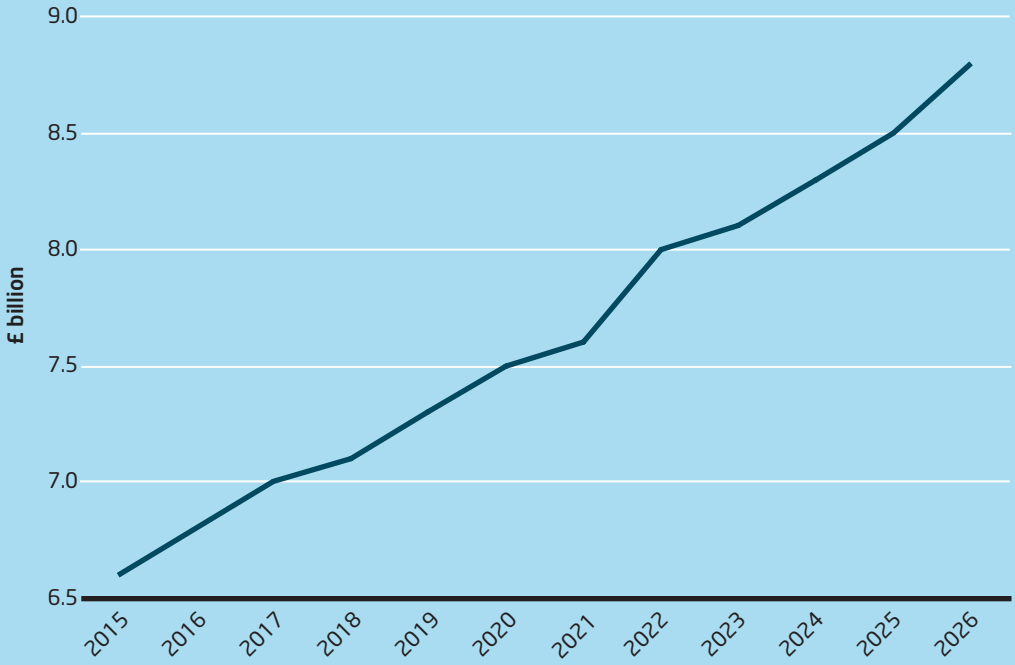
A variant of the comprehensive option is the idea of a care duty (Spiers 2008) that would be levied on people's estates after death. The thinking behind this approach has been informed by an increasing awareness of the considerable housing wealth of older people born in the post-war years and the intergenerational unfairness this will generate when diminishing numbers of working-age taxpayers are supporting the care costs of a relatively wealthy cohort of older people. The comprehensive option is a potential means of redressing that inequity as a 'one-generation' solution but needs to be part of a longer-term programme of reform.

Working-age adults

Thus far the updated estimates in this report relate to older people, as did those of the 2006 review. However the funding pressures arising from demography and higher aspirations now arise as much from the needs and aspirations of working-age people with care and support needs as they do from older people.

Under all of the new funding options discussed here, the likely outcome is that the majority of working-age people with care and support needs would continue to receive their care free. This is because either insurance-based options could not apply because

Figure 13 Total net social care expenditure on younger adults in England, 2015–2026



Source: Adapted from Wittenberg *et al* 2008.

the underlying need has already arisen, or more generally because people with disabilities and long-term conditions, unlike older people, tend not to have time or opportunity to accumulate savings and other assets. Working-age adults, supported through local authorities, have more than 95 per cent of their care costs covered by the public system.

It seems unlikely that these circumstances will change in the foreseeable future. On this basis public spend on social care for working-age adults (including care management and assessment costs) is projected to reach around £6.6 billion in 2014/15, rising to £8.8 billion in 2025/6 (*see* Figure 13, above). Very few people would be affected to any significant degree by a change in the funding system.

It is clear that higher expectations and changes in the pattern of informal care will affect future needs and demand. The funding needs for care and support for younger adults requires more detailed work.

The likelihood that the majority of working-age adults will continue to receive care and support free at the point of use has two major consequences for the reform of care funding. The first is that the policy question is primarily about the amount of public funding that will be needed to meet the needs and expectations of rising numbers of adults with disabilities and other needs, rather than the particular policy mechanism or funding option to be used. However, the projections of a £9 billion requirement by 2026 assumes current levels of support. More work is required to gain a better understanding of future funding needs and the implications of applying higher, benchmark levels of support in the same way as for older people.

The second consequence concerns the implications for wider system reform and the potential danger of developing completely different and unconnected arrangements

for future care funding. Historic demarcations between working-age and retired people will become blurred as conventional notions of retirement are eclipsed by more flexible lifestyle patterns, and new policies are scrutinised for age discrimination. Care and support needs do not respect neat dividing lines based on chronological age. People of all ages experience disability, episodes of ill-health or longer-term health conditions, and a new system of funding requires sufficient flexibility to accommodate changing needs and circumstances over time. Finally there are significant numbers of older people who, like their younger counterparts, have not been able to accumulate savings or property. A quarter of older people will not own their own homes in 2026 (Department for Communities and Local Government *et al* 2008) and this is not a situation of the older 'haves' and the younger 'have nots'. Inequalities exist within as well as between generations, as the report of the National Inequalities Panel has shown (Hills 2010).

International evidence also points to the potential pitfalls of adopting different policy solutions for older people and working-age people. In Germany, the Netherlands and Denmark, for example, a universal approach applies to all ages, whereas separate funding arrangements for older people have inhibited services for younger people with severe disabilities in Australia and have raised questions about intergenerational fairness in Japan. This should be a major consideration in designing a new system of care funding.

The scale of the additional resources required to meet current and future needs inevitably raises questions as to how and from where this money could be found, and whether more could be achieved by redesigning other funding streams that are closely related to care needs. The next section therefore examines options for the reform of Attendance Allowance.

5 Reforming Attendance Allowance

The Review recognises the importance of the financial help that Attendance Allowance provides, including support in meeting care costs and also compensating people for other needs-related expenditures. However, it appears that Attendance Allowance might not be the best vehicle to provide both forms of this financial help. The review recommends integrating support for care costs from Attendance Allowance into the care system to improve targeting of resources. It would be particularly difficult to sustain in its present form if the care system provided a guaranteed care entitlement to all those people who would, in theory, be eligible for Attendance Allowance.

(Wanless 2006)

Key points

- The conclusion of the 2006 review – that there was scope for improving its targeting and alignment with the care system – remains valid. The amount of public money spent on Attendance Allowance (AA) is significant and growing and in view of poor prospects for the public finances, the argument for its inclusion in the redesign of care funding is compelling.
- The policy shift towards personal budgets as the default operating model for adult social care creates a further argument for rationalising and simplifying disconnected funding streams.
- We consider here the consequences of a reform of AA whereby only new applicants who were in receipt of Pension Credit would be entitled to AA. This reform would ultimately free up around £3 billion a year by 2025/6 but some people would be hypothetical 'losers' (some potential new claimants with income above the Pension Credit levels would now lose entitlement).
- If an AA reform of this kind was combined with Partnership50%, then by 2026 the overall cost to the state (of both AA and social care) would be around the same as the means-tested model with unreformed AA. Public spending on social care would need to grow by around 4.5 per cent a year between 2015 and 2026 – not dissimilar to the rate of growth over the last 10 years.
- Without evidence of the impact of AA and social care expenditure on people's health and well-being we cannot make a judgement about whether this reform would produce better outcomes. What we can say is that the average level of need of people being helped would be higher for the Partnership50% option with reformed AA, and unmet need levels for care would be lower.
- However, as The King's Fund in our evidence to the Health Select Committee, 'It will be important to reassure those who are eligible for it that any new system will continue to offer the freedom and flexibility enjoyed by current recipients, so that it will represent a genuine enhancement of service and not simply a way of shifting costs between Whitehall departments.' (The King's Fund 2009)

The context

The improvements in modelling since 2006 allow us a better assessment of the consequences of reforming AA, a universal benefit for people over 65 who have a disability and as a result need help with personal care. AA expenditure in England in 2009 was approximately £3.7 billion a year with some 1.25 million recipients.

AA and the social care system have an overlapping concern with meeting care needs, but the two systems are largely independently administered. AA is a national entitlement benefit while publicly funded social care is run by local government and operates on a budget-constrained basis. In contrast with the social care system, assessment for AA is mostly paper based, and levels of the benefit do not vary between areas. There are some linkages between the systems – for example, AA is mentioned explicitly in the means-test used for assessing social care charges – but generally there appears to be significant scope to better align the operation of these two systems and ensure that public funding going to each is used rationally and consistently.

One of the main arguments put forward by the 2006 review was that AA helps people that (a) would not be eligible under the social care needs-test and (b) can have very high levels of wealth. There are clearly benefits for such people, but in a budget-rationed world questions need to be raised as to whether some of this benefit could be more efficiently re-allocated, for example to help higher needs social care users, or those people that fall just below social care needs eligibility thresholds. The review of free personal care in Scotland (Sutherland 2008) suggested that 'as many as 80 per cent of those applying for the allowance and satisfying the disability test would not satisfy local authority assessment for free personal care'.

A thorough analysis into the appropriateness of the targeting of AA and social care resources requires better research evidence on the consequences people experience as a result of having AA or social care. This research base is limited, particularly for AA use.

Here we present some analysis of who uses AA, based on data from the British Household Panel Survey (BHPS). Figure 14, overleaf, summarises an analysis of the relationship between uptake rates in the older population and their income. The results suggest that while poor people (those in lower income deciles) are more likely to be recipients, high income groups have a not insignificant chance of being recipients as well. This general pattern is to be broadly expected given that AA is a non-means-tested benefit.

People with higher needs are more likely to claim AA, where need is measured by the number of activities of daily living (ADL) problems such as washing, dressing and feeding that people report. The relationship between uptake and intensity of need can be seen in Figure 15, overleaf, the latter being indicated by the total number of ADL problems people report in the BHPS. The bars in the figure show the proportion of the population (65+) that claim AA v. Uptake rates increase steadily with ADL count up to three ADL problems, but declines thereafter. This decline may be due to very high need people being in care homes where publicly supported residents lose entitlement to AA. It may also be problems of under-reporting of AA receipt by the most dependent groups in the BHPS.

The line in the chart shows the total *numbers* of claimants by severity of need. Although the proportion of people with low needs claiming AA is relatively low, there are significantly higher numbers of the older population in these low need groups.

Figure 14 Uptake rates of Attendance Allowance – percentage of population 65+, 2006/7, by income decile

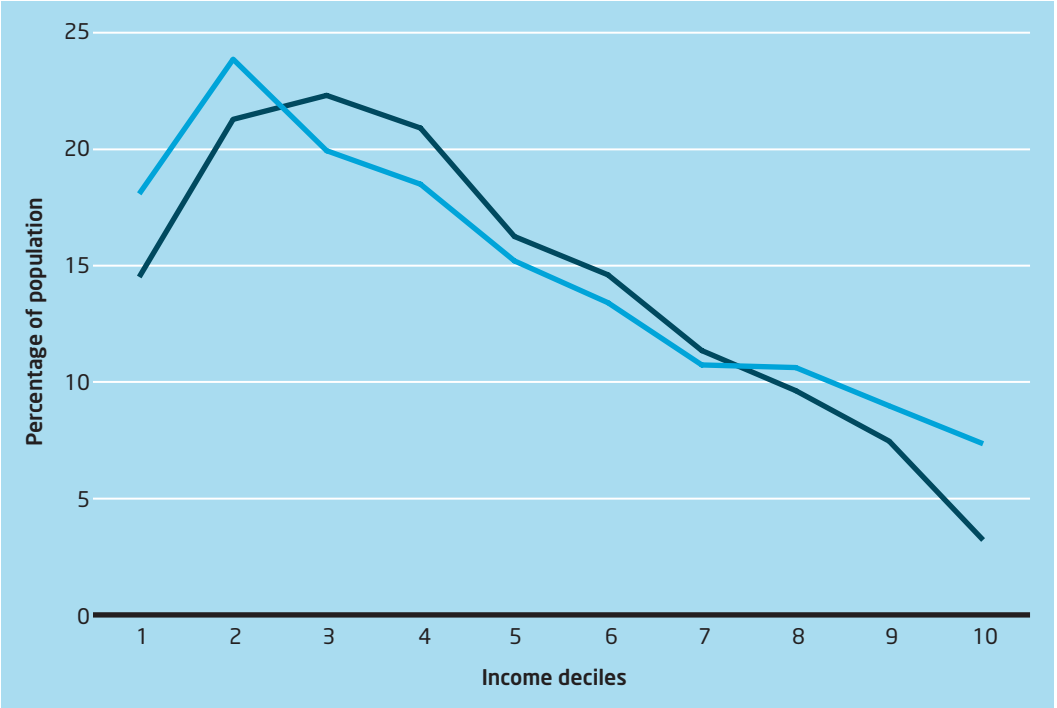
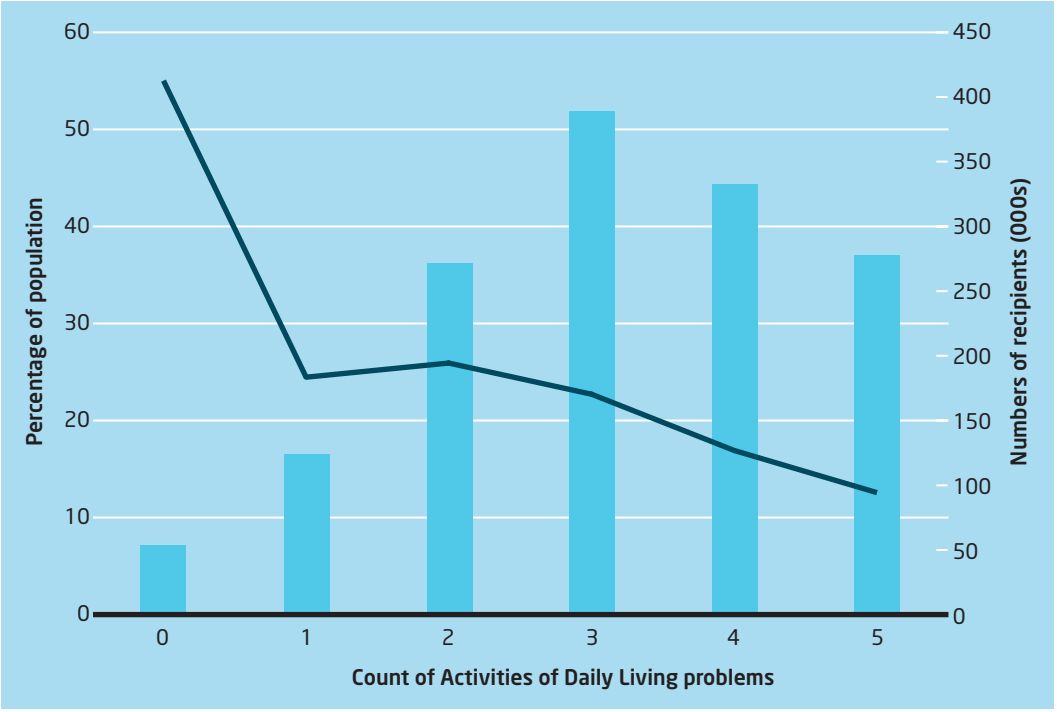


Figure 15 Uptake rates and numbers of recipients of Attendance Allowance in the population 65+, 2006/7, by level of need



These analyses suggest that potential exists for re-directing some of the spend on AA for higher income groups or for low need recipients into the care system. We can use the micro-simulation model to investigate the consequences of AA reform. The 2006 review (Wanless 2006) suggested that AA could be means tested for future cohorts of older people and/or that the eligibility test could be somewhat tightened. There is some suggestion that poorer people rely on AA as a source of additional general income. There are, for instance, provisions in the Pension Credit system linked to the receipt of AA which mean that people with a disability can claim greater financial support (the severe disability premium). One possible reform option would be to means-test AA so that only people in receipt of Pension Credit in the future would retain a claim to AA. Under this option, we assume a system of 'transitional protection' would apply so that people claiming AA before the reform implementation date would retain entitlement whatever their circumstances. There would therefore be no actual money losers.

There are particular issues concerning 'benefit traps', affecting people with higher income, that is some people could find that for every additional pound of pre-benefit weekly income, their level of benefit entitlement falls by more than one pound. In working-age populations there are particular concerns about these benefit traps, which offer significant disincentives to work. For retired populations, these concerns are less relevant. It is also the case that Severe Disability Premium is a lump-sum premium in the Pension Credit system. The reform considered here would work in a very similar fashion.

A redesigned Attendance Allowance?

We model an AA option where from 2014/15 new potential claimants who pass the current needs-test for AA but who are not eligible for Pension Credit would cease to have entitlement to AA. Potential claimants who pass the current needs-test for AA but who are eligible for Pension Credit would continue to receive AA on the same basis and at the same rates (in real terms) as currently. Furthermore, anyone in receipt of AA in 2013/14 would continue to be eligible for AA after 2014/15 under the current conditions.

These assumptions mean that savings from this reform in the early years after the implementation date would come from current recipients dying and only being replaced by new cohorts of needs-eligible people that are Pension Credit claimants. Analysis of AA data suggests that around 20 per cent of any given cohort of AA claimants will die in the following year. However, with a growing dependent population, they are outnumbered by new claimants and total numbers of AA recipients are projected to grow through time, other things being equal. The proportion of potential new claimants after the reform, by contrast, would be significantly below this number because new claimants will now need to be eligible for Pension Credit.

The spend on AA (unreformed) in 2014/15 is projected to be around £4.1 billion. If there were no new claimants at all after a new reform implemented from April 2014, then by the end of 2014/15 AA spend would be at approximately 80 per cent of its level in 2013/14, due to transitional protection. In other words, transitional protection arrangements mean that savings will only accrue gradually after the start of the reform. In our modelling we assume that in any given year, half of the recipients projected to die in that year will die in the first six months.

We model the impact of this AA reform assuming the Partnership50% model is also implemented. In practice, given the largely independent nature of AA from the care system, the projected new public expenditure requirements for AA do not change very much from one care funding system to another.

Table 4, below, gives the results of the model projections. The first column gives the projected AA spend if AA continued unreformed, running from £3.75 billion in 2010 to £5.13 billion in 2026. With AA reformed from April 2014 the expenditure requirement for 2015 would be £3.76 billion rather than the unreformed total of £4.12 billion, a saving of £0.36 billion. This saving increases to nearly £3 billion by 2025/6 by which time most of the originally protected recipients of AA have died.

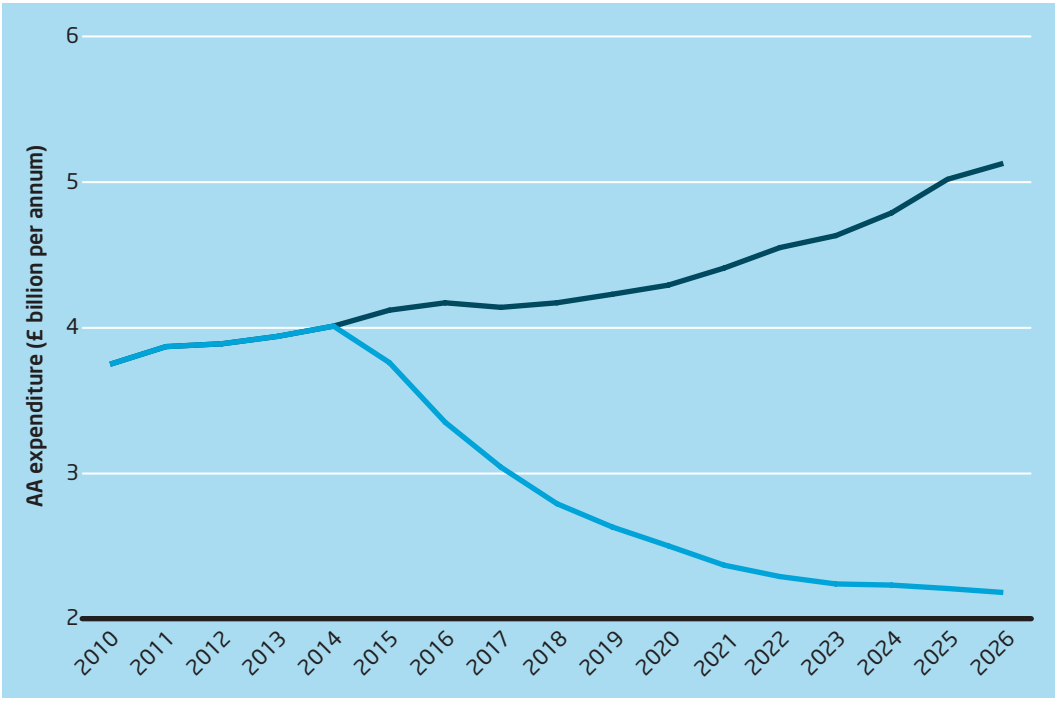
The table also shows the projected AA expenditure requirement if no transition protection was in place, that is that all people lose AA if they are not also receiving Pension Credit. In this case required expenditure would fall to £1.44 billion in 2014/15, only 35 per cent of the unreformed total. This percentage corresponds to the proportion of people in the older population that would pass the needs-test for AA and are eligible for Pension Credit. Note that this rate is somewhat higher than the rate of Pension Credit uptake in the over-65 population as a whole because people with disabilities tend to be poorer on average. The difference between the AA reformed total spend and the spend without transitional protection is the cost of transitional protection for the reform. It starts at £2.32 billion in 2014/15 and falls to £0.33 billion in 2025/6. We would need a slightly longer time series to see this transitional protection cost fall to zero (about 15 years after implementation).

Table 4 Projections for the cost impact of Attendance Allowance reform

Financial year ending	AA unreformed (£billions)	AA reformed (£billions)	AA saving (£billions)	AA with no transitional protection (£billions)	Transitional protection cost for AA reform (£billions)
2010	3.75	3.75	0	3.75	0
2011	3.87	3.87	0	3.87	0
2012	3.89	3.89	0	3.89	0
2013	3.94	3.94	0	3.94	0
2014	4.01	4.01	0	4.01	0
2015	4.12	3.76	0.36	1.44	2.32
2016	4.17	3.35	0.82	1.50	1.85
2017	4.14	3.04	1.10	1.51	1.53
2018	4.17	2.79	1.38	1.51	1.28
2019	4.23	2.63	1.60	1.58	1.05
2020	4.29	2.5	1.79	1.61	0.89
2021	4.41	2.37	2.04	1.64	0.73
2022	4.55	2.29	2.26	1.66	0.63
2023	4.63	2.24	2.39	1.69	0.55
2024	4.79	2.23	2.56	1.78	0.45
2025	5.02	2.21	2.81	1.79	0.42
2026	5.13	2.18	2.95	1.85	0.33

Figure 16, opposite, shows the profiles of projected reformed and unreformed AA expenditure requirement (produced from Table 4, above). The divergence between the lines shows the saving from AA reform. The AA reformed line will begin to turn upwards again after 2026.

Figure 16 Projected Attendance Allowance expenditure requirement



The overall state expenditure on social care and AA together for Partnership50% and reformed AA would be £17.8 billion in 2025/6. By contrast the same overall state cost for the existing system of care funding with unreformed AA would be £17.2 billion, that is, only 3 per cent less. In both these scenarios we are assuming the current care packages. In the long run therefore Partnership50%, if accompanied by reform of AA, has about the same cost to the public purse as the existing system plus unreformed AA. Without evidence of the impact of AA and social care expenditure on people's health and well-being we cannot make a judgement about whether this (same-cost) reform would produce better outcomes. What we can say is that the average level of need of people being helped would be higher for the Partnership50% option with reformed AA.

We can also compare hypothetical financial winners and losers. We again consider people who are service users at 2014/15 and look at how their lifetime net value of support (social care and AA and less any point-of-need charges), compares between reformed and unreformed systems.

Table 5, overleaf, shows that more than 94 per cent of service users in 2014/15 who have high needs would be better off. More than 78 per cent of low needs people would be better off. The maximum loss is the (hypothetical) loss of the higher rate of AA (about £66 per week in 2006/7 prices). We should note that transitional protection applies; future cohorts of new service users may be more adversely affected by AA reform – there will be some people who would have been entitled to AA under the old system but would not be entitled under a reformed system.

There would be no losers in residential care (*see* Table 6, overleaf).

Table 5 Partnership50% + Pension Credit reformed AA: Winners and losers, actual behaviour – all service types

Need		Wealth quintiles				
		Poor	Moderately poor	Moderate	Well-off	Very well-off
Low	Worse off (%)	12	22	21	17	16
	Mean loss (£s/wk)	-28	-31	-28	-32	-32
	Max loss (£s/wk)	-66	-66	-66	-65	-65
	Better off (%)	88	78	79	83	84
	Mean gain (£s/wk)	6	11	12	19	23
	Max gain (£s/wk)	94	94	95	148	119
High	Worse off (%)	3	5	6	5	3
	Mean loss (£s/wk)	-26	-30	-23	-28	-27
	Max loss (£s/wk)	-65	-65	-61	-65	-51
	Better off (%)	97	95	94	95	97
	Mean gain (£s/wk)	8	12	19	30	72
	Max gain (£s/wk)	96	98	108	121	154

Table 6 FPC winners and losers – residential care

Need		Wealth quintiles				
		Poor	Moderately poor	Moderate	Well-off	Very well-off
High	Worse off (%)	0	0	0	0	0
	Mean loss (£s/wk)	0	0	0	0	0
	Max loss (£s/wk)	0	0	0	0	0
	Better off (%)	100	100	100	100	100
	Mean gain (£s/wk)	6	13	25	31	73
	Max gain (£s/wk)	96	95	104	97	102

Finally, the Scottish experience is salutary. Scottish people receiving free personal care in a residential setting are not entitled to claim Attendance Allowance, and the resulting savings have gone to the Department for Work and Pensions (DWP) rather than being transferred to the Scottish government to help with care costs. The amount in question is now estimated to be around £30 million a year – almost as much as the projected FPC funding shortfall in Scotland.

This signals the importance of securing a commitment across government that any changes to future entitlement to Attendance Allowance are conditional on these resources being redirected into personal care budgets and not retained as savings. Any reform should be considered as part of a wider review of the costs and outcomes of public spending on older people.

6 Conclusions and ways forward

The case for change

The publication of the review *Securing Good Care for Older People* in 2006 (Wanless 2006) created a compelling case for change in reforming the social care system and helped to propel the issues up the political and policy agenda. Since then, accumulating evidence of the scale of unmet need, growing pressure on resources, and accelerating pace of demographic and social change have only reinforced the need for reform. This has been helped by new ideas and thinking about funding options, a progressive policy framework to transform the delivery of care through personalisation, and the experience of other countries. Emerging evidence of the value of prevention and early intervention points to how more could be achieved with existing – and new – resources.

But the most striking change since the review has been the stark deterioration in the state of public finances and the colder financial climate facing all public services over the next few years. Since 1997 adult social care has enjoyed a 53 per cent real-terms increase in resources, yet the impact of demographic and funding pressures has meant an ever tighter rationing of services, with the safety net of public support cast even higher (Commission for Social Care Inspection 2008). If the social care system was not sustainable during the years of plenty, the prospects for the lean years ahead look bleak. The need for reform has never been greater, but the timing could not be worse.

Doing nothing is the least palatable option. Our projections show that the cost of the existing system will almost double by 2026, yet without any improvement in the outcomes that could be achieved through radical reform. Very poor people would continue to be entitled to free, taxation-funded care; very rich people are in a position to afford the cost of their care; it is the very substantial numbers of older people in between – neither very poor or very rich – that would continue to suffer, experiencing an unpredictable mix of high contributions (especially if they need residential care), highly rationed care or unmet need (especially if their needs are less than 'substantial'). The most recent assessment by the Care Quality Commission reached a bleak conclusion that '…as the population ages and financial pressures grow, we expect that access to publicly-funded care will become further restricted' (Care Quality Commission 2010).

All of the options modelled and costed in this report will produce better outcomes but will cost substantially more than the existing system. This raises the question of how these costs should be shared between the individual and the state in a way that is fair and produces the best outcomes.

Under both the partnership and free personal care options, substantially more people would receive help and this accounts for much of the higher cost of these options compared to the existing system.

Free personal care is the simplest option and one that will be most clearly understood by the public. But it also involves the highest cost to the public purse, with a greater burden falling on working-age taxpayers. This could fuel potential unfairness between the generations. It would also serve to relieve the very wealthiest of all of their personal care costs, especially those needing residential care. It would cost £1.3 billion more than the partnership option and very few additional people would be helped.

Under the partnership model, whilst everyone benefits from 50 per cent of their costs met by the state, people with modest means would benefit particularly, as they would no longer face the 'cliff-edge' of the current means-tested system if they have savings or assets of £23,000 or more. The matched-funding component of the model would incentivise people to make a further private contribution from their own means; those who could not afford to do would have their contributions covered through Pension Credit. And the partnership option would require wealthier people to continue to make some contribution to the costs of their care.

All of the funding options discussed in this report, including the Green Paper options that we have been unable to cost, represent different mixtures of funding – general taxation, specific taxation social insurance, individual user charges and insurance. Most are not mutually exclusive, and the selection of which options to pursue will involve delicate balancing of political, economic and administrative criteria. On balance, our view is that a revised version of the original partnership model offers the best outcomes in relation to costs, and one that can be blended with other funding options to reflect the changing nature of trade-offs between costs, affordability and simplicity.

There is growing evidence on the costs and outcomes of social care to suggest that further public investment would represent good use of additional public resources, and there is a strong economic case for investment in social care (Glasby *et al* 2010). But the amount of additional resources needed is high, and if unmet need is to be seriously addressed, higher still. From 2015 to 2026, the Partnership50% model would require an annual average increase of £2.5 billion, and free personal care £3.5 billion. Offering higher levels of support would add a further £4–5 billion each year.

Can these resources be found? This is a long-term issue. By the time major reforms are implemented, the worst of the budget deficit will have been tackled, so current spending constraints must not be used as an excuse for inaction. Affordability involves political judgements and cannot be resolved through policy analysis alone. The relative priorities that should be given to competing claims against limited public funding are ultimately a matter for the government. There are opportunities to achieve more with existing public spending streams. Reforming the system of Attendance Allowance could release almost £3 billion by 2026. There are other areas of spending on older people that could be examined in a similar way, for example the £3.5 billion spent on free public transport, heating allowances and TV licences for older people, irrespective of need or wealth. Our 2006 review concluded that 'consideration should be given to whether a proportion of such funds would be better targeted at improving the provision of long-term care for older people'. Four years on, awareness of the opportunities, as well as the challenges of people living longer and healthier lives, suggests the need for a broader review of policies and spending plans that would result in a new settlement for older people.

Towards long-term reform – four steps

The evidence set out in this report suggests that fundamental reform to achieve a more sustainable funding system is both essential and possible, through four steps.

- Adopting a staged approach to funding reform with three elements:
  – implementing The King's Fund's partnership model and adjusting the mix of state and private contributions over time, avoiding the need to redesign the system again later on
  – considering the Green Paper's comprehensive option as a one-generation mechanism to attract immediate additional resources from the relatively wealthy cohorts of older people with high levels of housing wealth
  – reviewing the contribution from taxation towards care costs as the economy and the public finances recover.

- A fundamental spending review to achieve a new settlement for older people. A reformed social care system that delivers improved outcomes, access and fairness would be a big prize and would address one of the great injustices faced by older and disabled people. But it will inevitably mean confronting difficult trade-offs, including reforming AA. To ensure fairness between the generations as well as among the current generation of older people, the next spending review could be used to fundamentally review policies and spending on older people. This could look at wider issues in the context of people living longer, healthier lives, including the default retirement age, the re-indexation and level of the basic state pension, the current timetable for raising the state pension age and the range of entitlements currently available.

- Ensuring that the reform of funding is accompanied by reform of delivery. This will involve:
  – accelerating the pace of transforming adult social care
  – the ruthless pursuit of greater efficiency, innovation and productivity
  – a system shift towards prevention and early intervention; making faster progress in closer working with health and other services
  – identifying, understanding and tackling unjustifiable variations in use of resources.

  Above all it will mean ensuring that future decisions about use of resources, locally and nationally, are based on a sound evidence base about which investments will achieve best outcomes for people in relation to their cost. The case for a social care body charged with developing this seems incontrovertible. The close parallels with the well-established role of the Social Care Institute for Excellence and its knowledge of this area suggest an option that would avoid further organisational change or delay.

- Driving comprehensive reform by establishing a strategic, long-term framework for change, recognising that a transformed system will take years to achieve and will transcend the lifetime of a single parliament. This will require building a political consensus and an all-party road map for reform that will endure beyond a single parliamentary term.

Four years on from our original review, politicians are at last giving reform of the care and support system the priority it deserves. It is essential that the momentum gained is sustained and that the next government delivers the radical reforms so desperately needed. Not to do so would be to betray the current and future generations of people who rely on the care and support the system provides.

Appendix A
Technical notes and tables

Dynamic micro-simulation model

The estimates used in this report have been obtained using the Personal Social Services Research Unit's (PSSRU) improved, dynamic micro-simulation model, built around a representative sample of older people in England, who are aged through time. The model has been developed pooling data on 30,000 people over 65 from waves 3 to 15 of the British Household Panel Survey (BHPS). Due to its dynamic and micro nature, it can explore the distributional implications for the care and support system of alternative assumptions about factors such as disability rates, people's wealth, funding and care model policy scenarios, in the present as well as through time.

The model is constructed around two broad types of indicators:

- socio-economic profiles of older people, for example age, sex, wealth, need
- policy-derived factors, such as the type and level of care and support consumed, the amount of state funding received, and the size of out-of-pocket charges paid.

People's characteristics change as they age. If they survive from one year to the next, individuals in the sample can experience changes in their health condition, their marital status, living arrangements and in their income and wealth (independently of any effects of the care and support system). Dependency profiles are calculated on the basis of past health states and assumptions about present and future prevalence of disability (by age and gender). The level of state funding provided varies depending on the resources of the person in need (ie income and assets) and the eligibility rules of the funding system assumed in the model. Once the individual's own contributions are calculated, these payment levels are used to make a further adjustment to the person's savings.

The probability of dying between periods in the model is estimated as a function of a person's characteristics, including age, gender and health state. As indicated above, the overall probability of death was adjusted to ensure that the population in the model evolved in line with the 2006 Government Actuary's Department (GAD) population projections.

Numbers of older people in need of care

The revised analysis incorporates the latest 2006 GAD population projections, which revise significantly upwards the estimates of the number of older people in the future in England. As the analysis applies the original assumption of constant age and gender prevalence of disability, the volume of people in need of social care services in the future is higher than in the original estimations.

Income and assets

Net income (ie, gross income less any taxes) includes pensions, benefits, wages, asset return and other income. Two sets of benefits are particularly relevant for older people with care needs: Pension Credit and Attendance Allowance. For older people in the model in 2009/10, net income is estimated to have a mean of £230 per week and a median of £200 per week.

Non-housing assets include all forms of savings and assets other than the person's own home. For example, they include other properties, cars, personal wealth such as valuables and all forms of savings (bank accounts through to stocks and shares). Housing assets are the value of people's own home (domicile property). For the analysis we calculate the assets of either individual people – where people live alone or do not live with a recognised partner – and the assets of couples divided equally between the two people. This latter specification therefore creates a pseudo-individual level asset total for couples (Forder and Fernandez 2009, p 14). The median holding of non-housing assets is £8,700 per individual with the mean at £35,600. People in high-need groups have significantly fewer assets than people without disabilities.

We define wealth in terms of a combination of net income and non-housing assets, where each £500 worth of assets (over £6,000) is treated as an equivalent of £1 of income. For a number of purposes we divide the over 65 population into 5 quintiles of wealth.

Timing

The dynamic nature of the model allows us to specify future dates from which any reform of the care system will start. Government departmental budgets are currently set until the end of March 2011, and so we would expect any reform to be implemented after this date. Given that planning for the next Spending Review (SR) period would happen during 2010, this would give a very small window for decisions to be made in time for the April 2011 spending period. We therefore assume that reforms would start at the beginning of the following SR, ie, April 2014. The implications of changing this date for the results are relatively small since mainly we are concerned with comparing new models with the current system at any given time.

As well as a change in the funding system, the 2006 Wanless review recommended a significant increase in the levels of support (care packages) received by individuals with social care needs. Using the £20,000 per activities of daily living adjusted year (ADLAY) cost-effectiveness criteria (an approach which mirrors that used by the National Institute for Health and Clinical Excellence (NICE) for new health care interventions), the review found that additional levels of public support could be justified. In particular, levels of publicly funded support for people with moderate needs – who often fall outside of the current eligibility criteria operated by social care authorities – ought to be increased. In what follows we model both the current care 'offer' – that is, the level of support that people can expect currently from social care authorities – and the review's 'benchmark' levels of care, based on cost-effectiveness criteria. By way of terminology, we define the *normative* package as the base amount that is deemed to be required by someone with given assessed needs.

Benchmark levels of care and unmet need

The estimates of the unit costs of services used in the model have been updated in line with new Department of Health EX1 figures for the unit costs of services commissioned by local authorities in England. Since 2006, there have been significant (higher than general inflation) increases in unit costs of social care services, so that for each of the 20 years examined, the costs of care packages in the present analyses are higher than those assumed in the 2006 review.

Regardless of the funding arrangements in place, we can define a 'normative' level of care in the benchmark care system which is the level of support assessed as being needed in the public system, depending only on a person's needs-related characteristics and not their financial wherewithal. In practice, people can decide to buy more or less care than this level, and this decision depends on the nature of the financial rules in the funding system. The normative level of care is something of a standard against which we can judge the extent to which people's needs are being met.

Under the current system councils define need into four categories – critical, substantial, moderate and low – and set an eligibility threshold related to these need levels. This process is framed by the Department of Health's *Fair Access to Care* guidance (Department of Health 2003). People with needs below this threshold level are not offered support and their normative care packages are zero. Under benchmark care packages, the eligibility threshold is much lower, so that although very low needs people still have a normative package of zero, many more people would be offered help and so have a positive normative package. As an indication, under the current system all people with critical and substantial need levels are supported, as are about a third of people with moderate levels of need. With benchmark care, all people with moderate need and above are offered support. A small number of low needs people are also offered low-level equipment. The level of support increases with the need level of the person in question – see Table A1 below. This table gives the average level of support for the corresponding *Fair Access to Care* need group; within each group some people get more, some less. Also, these are just personal care costs – any costs associated with housing or practical care would be in addition to those in the table.

Table A1 Normative levels of (formal) support under benchmark care packages

Need level	Mean level of support (£s/wk)
Critical	229
Substantial	151
Moderate	96
Low	10
Total	119

In the partnership model, the guarantee and matching limits are set against these normative levels of care. For example, an average critical needs person would receive a guarantee of 66 per cent of £229, ie, £151 per week, and they would get matched contributions of £39 per week for the next £39 they paid into the system.

Costs

Table A2, below, lists the types of expenditure examined in the analysis of funding models. Overall, cost figures are broken down between types of expenditure (social care v disability benefits, care v accommodation costs) and sources of financing (state v private charges, private top-ups). In particular, we distinguish between people who are eligible for public support, ie those in the *public scheme*, and people who are not eligible and so buy care privately (*non-scheme* people). This is a generic distinction that applies to all funding models, although different models vary according to the proportions of people with care needs who are covered by the scheme or not. It is often possible for people covered by a scheme (and therefore getting public support) also to top up their public care with additional care support they buy privately. These people are counted as being in the scheme, but this additional care is funded out of their own pockets. Furthermore, most models require that people covered by the scheme pay a charge into the scheme which people also pay for out-of-pocket.

In the analysis of each model, the projected costs of Attendance Allowance (AA) are shown, but not included in the public costs of care. Whether it should be is examined separately in Section 4 Reforming Attendance Allowance (*see* pp 32–38). All costs in this report are in 2006/7 prices (ie they discount for general inflation levels).

Table A2 Costs examined in analysis of funding models

Net public cost – total state social care expenditure (excluding user charges) =	C1
Attendance Allowance (AA) spend	C2
Scheme charges (charges levied on individuals by the public scheme (excluding top-ups)),	C3
made up of:	
hotel costs of residential care	C4
care costs	C5
Scheme top-up charges (purchase of additional private care by people within the public scheme)	C6
Non-scheme charges – charges/fees paid by individuals not covered by scheme to buy care privately,	C7
made up of:	
hotel costs of residential care	C8
care costs	C9
Total private spend by service users,	C10
made up of:	
scheme charges, above	C3
scheme top-up charges	C6
non-scheme charges	C7
Total spend, public & private	C11
Made up of:	
total private spend by service users	C10
Net public cost, excluding attendance allowance	C1

Table A3 Costs to state and individuals of current means-testing system (2006/7 prices, £billion), current levels of support

Year	Net public SC cost	AA spend	People in public scheme				People not in scheme			All	
			Scheme charges	... Of which		Scheme top-up charges	Non-scheme charges	... Of which		Total spend by service users	Total spend
				Scheme hotel charges	Scheme care charges			Non-scheme hotel charges	Non-scheme care charges		
	C1	C2	C3	C4	C5	C6	C7	C8	C9	C10	C11
2009	6.3	3.7	1.8	1.3	0.5	0.6	4.4	1.8	2.5	6.7	13.0
2010	6.4	3.8	1.8	1.3	0.4	0.6	4.6	1.9	2.7	6.9	13.3
2011	6.7	3.9	1.9	1.5	0.4	0.6	4.5	1.9	2.7	7.0	13.7
2012	7.1	3.9	2.0	1.5	0.4	0.7	4.7	1.9	2.8	7.3	14.4
2013	7.4	3.9	2.1	1.6	0.5	0.7	5.0	2.1	2.9	7.7	15.1
2014	7.7	4.0	2.1	1.7	0.5	0.7	5.3	2.2	3.1	8.1	15.8
2015	8.1	4.1	2.3	1.8	0.5	0.7	5.1	2.1	3.0	8.2	16.3
2016	8.4	4.2	2.4	1.9	0.5	0.8	5.3	2.2	3.2	8.5	16.9
2017	8.6	4.1	2.4	1.9	0.5	0.8	5.9	2.4	3.4	9.1	17.7
2018	9.1	4.2	2.5	2.0	0.5	0.8	6.2	2.6	3.6	9.4	18.5
2019	9.3	4.2	2.5	2.0	0.5	0.9	6.6	2.7	3.9	9.9	19.2
2020	9.7	4.3	2.6	2.1	0.5	0.9	7.0	3.0	4.1	10.5	20.2
2021	10.1	4.4	2.8	2.2	0.6	1.0	7.3	3.0	4.3	11.1	21.1
2022	10.4	4.6	2.8	2.2	0.6	1.0	7.9	3.4	4.5	11.8	22.2
2023	10.8	4.6	2.9	2.3	0.7	1.1	8.0	3.4	4.6	12.0	22.8
2024	11.2	4.8	3.1	2.4	0.7	1.2	8.2	3.4	4.8	12.5	23.7
2025	11.7	5.0	3.3	2.5	0.8	1.4	8.5	3.5	5.0	13.1	24.8
2026	12.1	5.1	3.3	2.6	0.7	1.4	9.4	3.9	5.5	14.0	26.1

Table A4 Costs to state and individuals of The King's Fund Partnership50% model (2006/7 prices, £billion), current levels of support

Year (FY ending)	Net public SC cost	AA spend	People in public scheme				People not in scheme			All	
			Scheme charges	... Of which		Scheme top-up charges	Non-scheme charges	... Of which		Total spend by service users	Total spend
				Scheme hotel charges	Scheme care charges			Non-scheme hotel charges	Non-scheme care charges		
	C1	C2	C3	C4	C5	C6	C7	C8	C9	C10	C11
2015	10.1	4.1	5.3	3.7	1.6	2.0	1.0	0.2	0.8	8.3	18.5
2016	10.4	4.2	5.6	3.9	1.7	2.1	1.2	0.3	0.9	8.8	19.2
2017	10.7	4.1	6.0	4.2	1.8	2.2	1.2	0.3	0.9	9.4	20.1
2018	11.3	4.2	6.3	4.4	1.9	2.3	1.2	0.3	0.9	9.7	21.1
2019	11.6	4.2	6.6	4.6	2.0	2.5	1.2	0.3	0.9	10.3	21.9
2020	12.1	4.3	7.1	4.9	2.2	2.5	1.3	0.3	1.0	10.9	23.1
2021	12.8	4.4	7.4	5.1	2.3	2.8	1.5	0.4	1.1	11.6	24.3
2022	13.3	4.5	7.9	5.4	2.5	2.9	1.5	0.4	1.1	12.3	25.5
2023	13.7	4.6	8.0	5.5	2.6	3.1	1.5	0.4	1.1	12.7	26.4
2024	14.3	4.8	8.5	5.8	2.7	3.3	1.5	0.4	1.1	13.3	27.6
2025	14.9	5.0	8.7	6.0	2.8	3.6	1.6	0.4	1.2	13.9	28.7
2026	15.5	5.1	9.4	6.4	3.0	3.8	1.6	0.4	1.2	14.8	30.3

Table A5 Costs to state and individuals of The King's Fund Partnership66% model (2006/7 prices, £billion), current levels of support

Year (FY ending)	Net public SC cost	AA spend	People in public scheme				People not in scheme			All	
			Scheme charges	... Of which		Scheme top-up charges	Non-scheme charges	... Of which		Total spend by service users	Total spend
				Scheme hotel charges	Scheme care charges			Non-scheme hotel charges	Non-scheme care charges		
	C1	C2	C3	C4	C5	C6	C7	C8	C9	C10	C11
2015	10.7	4.1	4.8	3.8	1.1	2.1	1.1	0.2	0.8	8.0	18.7
2016	11.0	4.2	5.1	4.0	1.1	2.2	1.2	0.3	0.9	8.5	19.5
2017	11.4	4.1	5.5	4.3	1.2	2.3	1.3	0.3	0.9	9.1	20.4
2018	12.1	4.2	5.7	4.4	1.3	2.4	1.3	0.3	0.9	9.3	21.4
2019	12.4	4.2	6.1	4.7	1.4	2.6	1.2	0.3	0.9	9.8	22.2
2020	13.0	4.3	6.4	5.0	1.5	2.6	1.4	0.4	1.0	10.4	23.4
2021	13.6	4.4	6.7	5.2	1.6	2.9	1.5	0.4	1.1	11.1	24.7
2022	14.2	4.5	7.2	5.5	1.7	3.0	1.5	0.4	1.1	11.7	25.9
2023	14.6	4.6	7.4	5.7	1.7	3.3	1.6	0.4	1.1	12.2	26.8
2024	15.3	4.8	7.8	6.0	1.8	3.4	1.6	0.4	1.2	12.8	28.1
2025	15.9	5.0	8.1	6.2	1.9	3.7	1.7	0.5	1.2	13.4	29.3
2026	16.6	5.1	8.7	6.6	2.1	3.9	1.7	0.4	1.2	14.3	30.8

Table A6 Costs to state and individuals of The King's Fund Partnership50% model (2006/7 prices, £billion), benchmark levels of support

Year	Net public SC cost	AA spend	People in public scheme				People not in scheme			All	
			Scheme charges	... Of which		Scheme top-up charges	Non-scheme charges	... Of which		Total spend by service users	Total spend
				Scheme hotel charges	Scheme care charges			Non-scheme hotel charges	Non-scheme care charges		
	C1	C2	C3	C4	C5	C6	C7	C8	C9	C10	C11
2015	13.6	4.2	4.8	3.3	1.5	0.9	0.2	0.0	0.2	5.9	19.5
2016	14.2	4.2	5.1	3.5	1.6	0.9	0.2	0.0	0.2	6.2	20.3
2017	14.8	4.2	5.4	3.7	1.7	0.9	0.2	0.0	0.2	6.5	21.2
2018	15.5	4.1	5.7	3.9	1.8	0.9	0.2	0.0	0.2	6.8	22.3
2019	16.1	4.3	6.1	4.2	1.9	1.0	0.2	0.0	0.2	7.3	23.4
2020	16.9	4.4	6.2	4.2	2.0	1.0	0.2	0.0	0.2	7.4	24.3
2021	17.7	4.4	6.6	4.5	2.1	1.1	0.2	0.0	0.2	7.9	25.6
2022	18.3	4.5	7.2	4.9	2.3	1.1	0.2	0.0	0.2	8.5	26.7
2023	19.2	4.6	7.5	5.0	2.4	1.2	0.2	0.0	0.2	8.9	28.1
2024	19.9	4.7	7.6	5.2	2.5	1.3	0.3	0.0	0.2	9.1	29.1
2025	20.6	4.9	8.1	5.4	2.6	1.3	0.3	0.0	0.2	9.6	30.2
2026	21.3	5.1	8.5	5.6	2.8	1.4	0.3	0.0	0.3	10.1	31.4

Table A7 Costs to state and individuals of means-testing model (2006/7 prices, £billion), benchmark levels of support

Year	Net public SC cost	AA spend	People in public scheme				People not in scheme			All	
			Scheme charges	... Of which		Scheme top-up charges	Non-scheme charges	... Of which		Total spend by service users	Total spend
				Scheme hotel charges	Scheme care charges			Non-scheme hotel charges	Non-scheme care charges		
	C1	C2	C3	C4	C5	C6	C7	C8	C9	C10	C11
2009	8.6	3.8	1.9	1.1	0.7	0.3	3.6	1.4	2.2	5.7	14.3
2010	9.0	3.8	1.9	1.2	0.7	0.3	3.4	1.3	2.1	5.6	14.7
2011	9.4	3.9	2.0	1.3	0.7	0.4	3.3	1.3	2.0	5.7	15.1
2012	9.5	3.9	2.0	1.3	0.7	0.4	4.0	1.6	2.4	6.4	15.8
2013	10.1	4.0	2.1	1.4	0.7	0.4	4.1	1.5	2.5	6.6	16.7
2014	10.4	4.0	2.4	1.6	0.8	0.4	4.3	1.6	2.7	7.0	17.4
2015	10.9	4.2	2.2	1.5	0.8	0.4	4.8	1.8	2.9	7.4	18.3
2016	11.3	4.2	2.3	1.6	0.8	0.4	4.9	1.8	3.0	7.6	18.9
2017	11.7	4.2	2.4	1.6	0.8	0.4	5.2	2.0	3.1	8.0	19.8
2018	12.4	4.2	2.6	1.8	0.8	0.5	5.4	2.1	3.4	8.4	20.8
2019	12.8	4.3	2.7	1.8	0.9	0.5	5.8	2.2	3.6	9.1	21.8
2020	13.4	4.4	2.8	1.9	0.9	0.6	5.9	2.3	3.6	9.2	22.5
2021	14.1	4.4	2.9	1.9	0.9	0.6	6.2	2.5	3.7	9.7	23.7
2022	14.4	4.5	3.0	2.0	1.0	0.6	6.8	2.7	4.1	10.4	24.8
2023	15.1	4.6	3.1	2.0	1.0	0.6	7.2	2.9	4.3	10.8	26.0
2024	15.6	4.7	3.2	2.2	1.0	0.6	7.1	2.8	4.3	10.9	26.5
2025	16.0	4.9	3.2	2.2	1.0	0.8	7.7	3.0	4.7	11.6	27.7
2026	16.5	5.1	3.2	2.2	1.0	0.8	8.3	3.2	5.1	12.3	28.8

Numbers receiving help

Table A8 Partnership model – number of recipients (millions), current support

Year	Scheme recipients	Non-scheme (private) recipients	Non-service users with some need	Number of people with some need
2015	1.44	0.12	0.69	2.25
2016	1.47	0.12	0.7	2.3
2017	1.49	0.13	0.73	2.35
2018	1.54	0.13	0.74	2.41
2019	1.57	0.13	0.75	2.45
2020	1.6	0.14	0.78	2.52
2021	1.66	0.13	0.8	2.6
2022	1.7	0.14	0.82	2.66
2023	1.73	0.15	0.85	2.72
2024	1.78	0.14	0.85	2.77
2025	1.78	0.15	0.9	2.84
2026	1.83	0.16	0.9	2.89

Table A9 Partnership model – number of recipients (millions), benchmark support

Year	Scheme recipients	Non-scheme (private) recipients	Non-service users with some need	Number of people with some need
2015	1.72	0.0	0.51	2.25
2016	1.73	0.0	0.54	2.3
2017	1.78	0.0	0.54	2.35
2018	1.81	0.0	0.56	2.41
2019	1.88	0.0	0.58	2.45
2020	1.91	0.0	0.6	2.52
2021	1.96	0.0	0.61	2.6
2022	1.99	0.0	0.64	2.66
2023	2.06	0.0	0.64	2.72
2024	2.08	0.0	0.67	2.77
2025	2.11	0.0	0.69	2.84
2026	2.16	0.0	0.68	2.89

Table A10 Means-testing model – number of recipients (millions), current support

Year	Scheme recipients	Non-scheme (private) recipients	Non-service users with some need	Number of people with some need
2010	0.87	0.3	0.82	1.99
2011	0.89	0.29	0.84	2.02
2012	0.89	0.3	0.89	2.08
2013	0.93	0.31	0.91	2.15
2014	0.93	0.33	0.94	2.2
2015	0.95	0.31	0.98	2.25
2016	0.98	0.32	1	2.3
2017	0.99	0.34	1.02	2.35
2018	1	0.35	1.06	2.41
2019	1.01	0.37	1.07	2.45
2020	1.02	0.38	1.13	2.52
2021	1.06	0.39	1.15	2.6
2022	1.07	0.41	1.18	2.66
2023	1.09	0.41	1.22	2.72
2024	1.12	0.42	1.23	2.77
2025	1.13	0.42	1.28	2.84
2026	1.12	0.46	1.31	2.89

Table A11 Means-testing model – number of recipients (millions), benchmark support

Year	Scheme recipients	Non-scheme (private) recipients	Non-service users with some need	Number of people with some need
2010	1.03	0.23	0.7	1.99
2011	1.06	0.22	0.73	2.02
2012	1.06	0.25	0.76	2.08
2013	1.07	0.27	0.79	2.15
2014	1.1	0.28	0.8	2.2
2015	1.1	0.3	0.83	2.25
2016	1.11	0.3	0.88	2.3
2017	1.14	0.3	0.89	2.35
2018	1.17	0.31	0.89	2.41
2019	1.2	0.33	0.94	2.45
2020	1.21	0.32	0.97	2.52
2021	1.23	0.33	1	2.6
2022	1.24	0.36	1.04	2.66
2023	1.29	0.38	1.04	2.72
2024	1.28	0.37	1.1	2.77
2025	1.28	0.4	1.12	2.84
2026	1.31	0.41	1.13	2.89

Unmet need

Because of the charges at the point of need that some people are faced with, some people with a disability will not take up formal care, or will take less care than the target (normative) level. How do we assess the implications of this situation? Clearly, people with activities of daily living (ADL) care needs who do not receive formal care and have no informal care will have some level of 'unmet' need. The demand behaviour of service users can therefore generate unmet need, depending on how strong their response to charges is, and what we consider to be the level of support for which needs are fully 'met'. Also, our estimate of unmet need will vary depending on the extent to which we take into account the support provided by informal carers. The approach we take in the analysis is as follows.

- We assume the normative package of care (expressed as hours of care) represents the target level of support at which no needs remain unmet. As described, normative packages depend only on people's needs-characteristics.
- People who receive formal and informal care inputs at least equal to the normative package of care have no unmet need.
- People who have total inputs that fall short have unmet need equal to the shortfall. This includes people that have a need for a care home place but decide instead to take a community care place where the care hours are less than they would have received in a care home.

Any 'deficit' approach to counting unmet need treats an hour's worth of shortfall in a care package as equal whatever the needs level of the person in question. Potentially this could mean that a system that only failed to support low needs people (albeit a relatively

large number since there are more low needs people) could have more unmet need than a system that catered well for low needs people but failed significantly to meet the needs of high needs people. We address this problem in the model by reducing the target level of support to zero for people with a *Fair Access to Care* need level of 'low' (or none). Unmet need so measured is therefore equal to zero for people with a low (or none) need level, regardless of the amount of care these people receive. This assumption means that our unmet need measure is likely to be an under-estimate of the actual total.

The normative package of care is determined according to which care and assessment model is assumed to be in place, that is, either the current packages or the benchmark packages. Therefore levels of unmet need will depend on this choice. As an alternative we also provide unmet need levels relative to the Wanless benchmark when modelling current care packages.

Table A12 Partnership model: Levels of unmet need and numbers of people with unmet need, current packages

Year	Unmet (current) need inc informal care (millions of hours per annum)		Unmet benchmark need (inc informal care) (millions of hours per annum)	
	Means testing	Partnership	Means testing	Partnership
2010	98.90		139.46	
2011	98.81		139.56	
2012	104.59		143.96	
2013	102.86		145.57	
2014	105.83		143.40	
2015	109.03	52.46	155.09	72.06
2016	111.06	55.72	151.42	69.61
2017	110.76	51.38	149.05	66.68
2018	116.84	56.35	158.52	73.28
2019	121.26	56.64	164.63	75.54
2020	118.49	52.72	164.90	71.51
2021	128.46	55.96	178.47	76.84
2022	127.68	54.20	181.55	76.72
2023	138.52	60.08	186.00	77.32
2024	142.22	61.63	193.27	81.67
2025	143.84	62.35	192.27	77.75
2026	144.66	58.99	200.59	80.02

Some of the unmet need relative to the benchmark level of care outlined in the above table occurs because people in the public scheme are offered the current level of care. If they are offered instead the benchmark levels of care, unmet (benchmark) need should be lower, and this is indeed the case – *see* Table A13, overleaf.

Both tables assume that the state offer is equivalent to the current average levels of local authority support in England. Unmet need can occur for two reasons. First, people secure less support than the normative level of care (for a person with their level of need). This generally occurs where people are required to pay charges for their care at the point of use but due to unwillingness or inability to pay, decide to take less than the normative level of care. Second, the prevailing normative level of care is itself insufficient to meet people's needs. It is difficult to make a judgement as to the size of a 'sufficient' level of input. The 2006 review looked at this issue by assessing both a cost-effective level of

Table A13 Partnership model: Levels of unmet need and numbers of people with unmet need, benchmark care

Year	Unmet benchmark need (inc informal care) (millions of hours per annum)	
	Means testing	Partnership
2010	93.82	
2011	95.5	
2012	98.21	
2013	95.32	
2014	99.43	
2015	105.39	42.96
2016	108.83	41.51
2017	110.43	43.34
2018	111.5	44.71
2019	114.79	43.89
2020	121.33	44.35
2021	129.45	48.46
2022	129.08	47.2
2023	133.16	50.26
2024	146.63	51.97
2025	152.02	56.29
2026	153.37	55.02

input (the benchmark level) and also triangulating this with professional judgement as to the specification of satisfactory levels of support. We continue in this analysis to use the benchmark level as the objective reference point.

Under means testing, people meeting the asset means-test are offered the normative care package and are charged on the basis of their income. Often this charge is relatively low and so the vast majority of people are happy to pay and take the care offered. A small number of people will refuse to pay charges and so receive no public service support. These people will experience unmet need.

People that do not qualify for public support face the full cost of care themselves. Even though relatively wealthy, these people may decide to get the minimum of private support that they need, or to delay seeking formal care altogether. This is a relatively small number of people, but without any support their unmet need levels are very high. This unmet need mostly stems from the high charges some people can face given the stark 'cliff-face' asset test in the current model. People with savings that are above this level (£23,000 currently) – who are really not that wealthy – face the full costs of care (at least until their assets reduce). This test is removed in the partnership model.

In theory we might cost unmet need by applying the unit of cost of an hour of care input. This would not, however, be the public expenditure requirement of removing unmet need because additional public spending crowds out private spending on care and also levels of informal care that are available. In other words, if the state provided more support, people would reduce the amount of care they buy privately or achieve through informal care. This reduction on average would be less than one-for-one, so that more public support translates into higher total care use, but this crowding out means that each extra publicly provided hour of care translates into only a small proportion of an hour being actually added to the total of public and private. It would therefore cost considerably more on the public purse than this 'unmet need cost'.

Drawing on assets ('spend-down')

So an important criterion in judging alternative funding systems is how they impact on people's ability to pay, and in particular, the degree to which people can pay care charges out of income or whether they have to draw on – or 'spend-down' – their assets.

Care charges are clearly not the only call on people's income. We therefore subtract an estimated *cost of living* amount from people's net income to determine their residual income. The cost of living amount is equal to the minimum income guarantee of Pension Credit for people living in the community. For people in care homes, this amount is set equal to the personal allowance (in that most living costs are covered by the home). We also subtract the person's care charge (including hotel costs for residential care). Pension Credit should ensure that people's imputed income is at least equal to the minimum guarantee. However, this benefit also assesses an income stream from assets so actual income can fall short of the minimum. On the basis of this analysis, around 8.5 per cent of the general population without care needs draw on assets in any given year.

To assess the effects of care charges on spend-down risk we need to look at the profile of expenditure through time. The analysis looks at the implications for people receiving services in 2015 in two groups: (a) those people that are in care homes at this time and thereafter for their lifetime and (b) those people that are non-residential service users and never enter residential care. This distinction is made because spending of assets and savings is expected to be much higher for people in care homes. We look at 2015 as it is about mid-point in our 20-year time series.

Table A14, below, for Partnership50% and Table A15, overleaf, for means testing (MT) give details of the amount that service users in 2015 have to draw on assets (ie, spend more than their income) over the period 2015 to death or to 2026, whichever comes first. The tables report the amount of spend-down that results directly from paying care charges, as distinct from any spend-down the person might have incurred regardless of care charges. Furthermore, we only consider charges associated with the normative package, that is, that amount of care a person ought to have to avoid unmet need. Some people will buy more care than this amount and so draw down assets faster than that suggested in the table. Some people will buy less. Also, we are considering people that are service users in 2015; they may have been service users in previous years and so have already drawn down on some assets.

Table A14 Spend-down characteristics – Partnership50%

	Residential care			Non-residential		
	Probability of spending down over period	Average period spend-down (£s)	Total period spend-down of assets (£billion per annum)	Probability of spending down over period	Average period spend-down (£s)	Total period spend-down of assets (£billion per annum)
Not MT entitled	0.95	-21,890	-2.88	0	-250	-0.04
MT entitled	0.14	-160	-0.03	0.01	-10	0
All	0.46	-8,760	-2.91	0	-100	-0.04

Table A15 Spend-down characteristics – means testing

	Residential care			Non-residential		
	Probability of spending down over period	Average period spend-down (£s)	Total period spend-down of assets (£billion per annum)	Probability of spending down over period	Average period spend-down (£s)	Total period spend-down of assets (£billion per annum)
Not MT entitled	0.99	-27,810	-3.65	0.18	-870	-0.13
MT entitled	0.14	-160	-0.03	0.01	-20	<0.01
All	0.48	-11,110	-3.68	0.08	-360	-0.13

We distinguish between people that are entitled to state support under means testing at the beginning of 2015 and those that are not. (There is a small number of people that become entitled for state support during the year – because they started just above the eligible asset level spend-down takes them below the threshold before the 52 weeks are completed. In the model, residents in this case will begin to receive state support at some point within the year. In the tables this benefit is still attributed according to their eligibility status at the beginning of the year. We exclude the very small number of people that start as MT entitled in 2015 but lose this entitlement between that time and 2026. We wish only to compare people that are always entitled or always not entitled.) We make this distinction because the latter people bear the full care and hotel costs so reduce their assets much more than people who are entitled. For example, for residential care residents under the means-tested model, those who are entitled spend-down less than £200 on average over their lifetime. Those not entitled, paying the full costs themselves, spend-down an average of more than £27,810. (This figure is the average of all people in the sub-group including those people with zero spend-down. Some people will spend-down significantly above this average.) Some people spend-down much more than the average. We also use this distinction to classify people under partnership (even though this means-test is not relevant) to compare like-with-like. For example, residential care people that would not have been eligible under means testing, would spend-down an average of £21,890 under partnership, approximately a quarter less spend-down than for means testing.

Spend-down for non-residential care is much lower mainly because people do not pay hotel costs. In fact it is the means testing of hotel costs under partnership which really leads to people having to draw on their assets. It should be remembered nonetheless that in moving (to a care home) people are realising a substantial asset in the form of their previous home. Many people without care needs who either downsize by buying a smaller property or move into rented accommodation expect to have to use part of their housing equity in the process. Since the average house price is significantly above £30,000, people are still left with a sizeable chunk of savings after incurring these costs. The problem really arises for those people that need a high level of care early in their life and for a long period and so could spend hundreds of thousands on care. Insurance offers one option to cover such catastrophic costs, but the partnership model would reduce the risk to the individual.

Winners and losers

To compare total lifetime net benefits of each option, we look at people who were care recipients in 2014/15 and track the value of support they receive from the state (we include Attendance Allowance and Disability Living Allowance as 'benefits' from the state) less their charges over their remaining lifetime (or up to 20 years if that comes first). People that totally self-fund (and do not receive Attendance Allowance or Disability Living Allowance) have a lifetime net benefit of zero (because they pay the full cost of their care which equals the value of the care they receive). Most people in the scheme will see a positive net benefit because for some duration they pay lower charges than the value of their care (where the scheme pays the remainder).

We again distinguish between people in residential care and non-residential care in 2014/15 and those who were entitled to state help through means testing or not at that time. Since there are slightly fewer people in residential care under means testing (due to the demand effect) we exclude the few people in residential care under one system but not the other. The results are shown in Figure 12, p 27.

We can also consider 'distributional' effects, that is, who benefits and who loses. The following set of tables show the difference in net benefit from the two systems, that is, the net benefit (in £s) for people under Partnership50% less the net benefit (in £s) of the same person if they were in the means-tested system. Positive values indicate that the person would be better off under partnership than means testing. Negative values mean that person would be a hypothetical loser, that is, would get less from the scheme under partnership than under means-testing. The tables distinguish between people by need (count of ADL problems) and wealth quintile (including an assessed income stream from assets).

The tables show:

- the percentage of people that are worse off under partnership compared with means testing
- the mean amount by which people are worse off per week for all people that are actually worse off
- the maximum amount by which the worst affected person is worse off per week
- the percentage of people that are equally or better off under partnership compared with means testing
- the mean amount by which people are better off per week over all people that are better off
- the maximum amount by which the best affected person is better off per week.

Table A16, overleaf, describes winners and losers between the two systems for the period 2014/15 and 2026 (or death) for people who were service users of any type (domiciliary or residential care) in 2014/15. Overall, it is clear that the vast majority of people, with either high or low needs, are no worse off and often significantly better off under partnership. For the very few people that are worse off, the average loss per week compared to what they would benefit from under means-testing is relatively small.

Table A16 Partnership50%: winners and losers, actual behaviour – all service types

Need		Wealth quintiles				
		Poor	Moderately poor	Moderate	Well-off	Very well-off
Low	Worse off (%)	1	6	9	2	0
	Mean loss (£s/wk)	-4	-2	-3	-3	0
	Max loss (£s/wk)	-13	-11	-18	-7	0
	Better off (%)	99	94	91	98	100
	Mean gain (£s/wk)	6	11	14	21	26
	Max gain (£s/wk)	94	94	99	124	119
High	Worse off (%)	0	1	1	1	0
	Mean loss (£s/wk)	-7	-2	-3	-4	0
	Max loss (£s/wk)	-7	-7	-7	-11	0
	Better off (%)	100	99	99	99	100
	Mean gain (£s/wk)	8	12	19	31	76
	Max gain (£s/wk)	96	97	108	123	154

It is only people in the low needs group that might lose a more significant amount. In particular, 9 per cent of people in the moderate wealth quintile and low needs group are projected to be worse off and would lose an average of £3 per week. The worst affected is £18 per week worse off under this partnership system. This result in part stems from choices that these individuals make themselves. Under partnership they would be free to make different choices about the amount of care they receive even if it makes them worse off in this winners and losers comparison. These differences occur because further state 'matched' funding under the Partnership50% option is dependent on individual contributions.

Under means testing, a small proportion of well-off people are eligible for state support – generally, income rich but asset poor people (by virtue of a specific combination of income and assets and the sharp cut-off points in the means-test). Their high income means that they would be asked, nonetheless, to pay a relatively high charge for their state support. The amount of support is fixed at the normative level commensurate with their assessed need. Under partnership, the same person would get 50% of the assessed care package for free and then would decide how much to top-up. Often such individuals do not top-up by as much as they would be asked to pay under the means-tested system. They, in other words, choose a smaller package at a lower cost. But if they did actually pay the same charge under partnership as they would be required to pay under means testing, they would be relatively much better off.

In Table A17, opposite, we model winners and losers assuming that people choose a top-up charge that is no less than they would be required to pay under means testing.

In this case, the proportion of people that are worse off is much reduced. Now only a maximum of 2 per cent of people with low needs appear to be worse off under partnership compared to the means-tested system. This comparison is appropriate because it does not allow the partnership model to be penalised simply because it gives more choice and that some people will make different choices, even if this makes them worse off in theory in terms of a comparison with means-tested system.

Table A17 Partnership50%: winners and losers, potential behaviour – all service types

Need		Wealth quintiles				
		Poor	Moderately poor	Moderate	Well-off	Very well-off
Low	Worse off (%)	1	2	2	1	0
	Mean loss (£s/wk)	-5	-2	-3	-4	0
	Max loss (£s/wk)	-13	-11	-15	-4	0
	Better off (%)	99	98	98	99	100
	Mean gain (£s/wk)	6	11	14	21	26
	Max gain (£s/wk)	94	94	100	124	119
High	Worse off (%)	0	1	1	1	0
	Mean loss (£s/wk)	-7	-3	-3	-4	0
	Max loss (£s/wk)	-7	-7	-7	-11	0
	Better off (%)	100	99	99	99	100
	Mean gain (£s/wk)	8	12	19	31	76
	Max gain (£s/wk)	96	98	108	123	154

The original partnership model was designed to be particularly beneficial to those people with a real need for residential care, that is, the highest need, most vulnerable groups. As shown previously (pp 53–4), the means-tested model can produce very high levels of spend-down for residential care people that are not eligible for state support, forcing many to sell their former homes. By contrast, the partnership model helps these people significantly – everyone requiring residential care would be better off under the partnership option than under the existing means-tested system, as Table A18, below, shows. The partnership system therefore plays an important 'insurance' role, in moderating the financial risk associated with the need for social care, and in particular for residential care.

Table A18 Partnership50%: winners and losers, residential care – all service types

Need		Wealth quintiles				
		Poor	Moderately poor	Moderate	Well-off	Very well-off
High	Worse off (%)	0	0	0	0	0
	Mean loss (£s/wk)	0	0	0	0	0
	Max loss (£s/wk)	0	0	0	0	0
	Better off (%)	100	100	100	100	100
	Mean gain (£s/wk)	7	13	25	31	78
	Max gain (£s/wk)	96	95	104	97	102

Free personal care

We model free personal care (FPC) using the current levels of support provided to people in the public system, that is, where people in the future would be offered the same level of care, as determined by their level of assessed need, as is the case currently. Based on current expenditure data we assume that 70 per cent of the current care package that people receive is personal care and therefore available without charge.

Table A19 Costs to state and individuals of FPC (2006/7 prices, £billion), current levels of support

Year (FY ending)	Net public SC cost	AA spend	People in public scheme				People not in scheme			All	
			Scheme charges	... Of which		Scheme top-up charges	Non-scheme charges	... Of which		Total spend by service users	Total spend
				Scheme hotel charges	Scheme care charges			Non-scheme hotel charges	Non-scheme care charges		
	C1	C2	C3	C4	C5	C6	C7	C8	C9	C10	C11
2015	10.7	3.9	5.6	4.3	1.3	1.7	1.1	0.3	0.9	8.4	19.2
2016	11.1	4.0	5.8	4.5	1.3	1.8	1.2	0.3	0.9	8.8	19.9
2017	11.5	4.0	6.2	4.8	1.4	1.9	1.3	0.3	0.9	9.3	20.8
2018	12.2	4.0	6.4	4.9	1.4	2.0	1.3	0.4	1.0	9.6	21.8
2019	12.5	4.1	6.8	5.3	1.6	2.1	1.3	0.3	1.0	10.1	22.7
2020	13.1	4.1	7.1	5.5	1.6	2.2	1.5	0.4	1.1	10.7	23.8
2021	13.8	4.2	7.4	5.6	1.7	2.4	1.6	0.5	1.1	11.3	25.1
2022	14.4	4.2	7.9	6.1	1.8	2.5	1.6	0.5	1.2	12.0	26.3
2023	14.8	4.3	8.1	6.2	1.9	2.7	1.7	0.5	1.2	12.5	27.3
2024	15.5	4.5	8.6	6.6	2.0	2.8	1.7	0.5	1.2	13.2	28.6
2025	16.1	4.6	8.8	6.8	2.1	3.1	1.8	0.5	1.2	13.7	29.8
2026	16.8	4.8	9.3	7.2	2.2	3.3	1.9	0.6	1.3	14.5	31.4

Table A20 Number of recipients of free personal care (millions), current support

Year	Scheme recipients	Non-scheme (private) recipients	Non-service users with some need	Number of people with some need
2015	1.44	0.13	0.68	2.25
2016	1.47	0.13	0.7	2.3
2017	1.49	0.13	0.73	2.35
2018	1.54	0.14	0.74	2.41
2019	1.58	0.13	0.74	2.45
2020	1.6	0.14	0.78	2.52
2021	1.67	0.14	0.79	2.6
2022	1.7	0.14	0.82	2.66
2023	1.73	0.15	0.84	2.72
2024	1.78	0.15	0.85	2.77
2025	1.79	0.15	0.89	2.84
2026	1.84	0.16	0.89	2.89

Table A21 Levels of unmet need and numbers of people with unmet need, current packages of free personal care

Year	Unmet (current) need inc informal care (millions of hours per annum)	Number of people with high dependency and unmet (current) need (millions of people)	Average unmet (current) need - high need (millions of hours per annum)	Unmet (current) need (no informal care) (millions of hours per annum)
2015	38.93	0	-	121.11
2016	42.27	0	-	133.58
2017	41.44	0	-	132.68
2018	41.05	0	-	136.2
2019	42.51	0	-	143.81
2020	38.87	0	-	145.85
2021	41.81	0	-	147.86
2022	40.89	0	-	149.6
2023	44.76	0	-	162.06
2024	43.76	0	-	160.16
2025	44.74	0	-	167.45
2026	38.70	0	-	159.74

Table A22 Spend-down characteristics of free personal care

	Residential care			Non-residential		
	Probability of spending down over period	Average period spend-down (£s)	Total period spend-down of assets (£billion per annum)	Probability of spending down over period	Average period spend-down (£s)	Total period spend-down of assets (£billion per annum)
Not MT entitled	0.93	-17,310	-2.3	0	-190	-0.04
MT entitled	0.14	-170	-0.03	0	0	0
All	0.45	-6,970	-2.33	0	-80	-0.04

Table A23 Total lifetime net benefit (mean) of free personal care

	Residential	Non-residential
Not MT entitled	£32,160	£6,650
MT entitled	£56,640	£17,070
All	£46,900	£12,940

Table A24 Winners and losers of free personal care, actual behaviour – all service types

Need		Wealth quintiles				
		Poor	Moderately poor	Moderate	Well-off	Very well-off
Low	Worse off (%)	0	0	0	0	0
	Mean loss (£s/wk)	0	0	0	0	0
	Max loss (£s/wk)	0	0	0	0	0
	Better off (%)	100	100	100	100	100
	Mean gain (£s/wk)	8	14	16	26	29
	Max gain (£s/wk)	180	182	180	181	187
High	Worse off (%)	0	0	0	0	0
	Mean loss (£s/wk)	0	0	0	0	0
	Max loss (£s/wk)	0	0	0	0	0
	Better off (%)	100	100	100	100	100
	Mean gain (£s/wk)	11	20	33	46	108
	Max gain (£s/wk)	184	188	184	185	195

Table A25 Winners and losers of free personal care – residential care

Need		Wealth quintiles				
		Poor	Moderately poor	Moderate	Well-off	Very well-off
High	Worse off (%)	0	0	0	0	0
	Mean loss (£s/wk)	0	0	0	0	0
	Max loss (£s/wk)	0	0	0	0	0
	Better off (%)	100	100	100	100	100
	Mean gain (£s/wk)	11	29	43	55	126
	Max gain (£s/wk)	184	188	184	185	195

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