
A new settlement for health and social care

Final report

This is the final report of the independent Commission on the Future of Health and Social Care in England.

Commissioners

Chair: Dame Kate Barker CBE, a business economist who is a former member of the Bank of England's Monetary Policy Committee and now holds a number of non-executive posts

Geoff Alltimes CBE, chair of the Local Government Association's multi-agency task group on health transformation and previously Chief Executive of Hammersmith and Fulham Council and NHS Hammersmith and Fulham

Lord Bichard, cross-bench peer and Chair of the Social Care Institute for Excellence

Baroness Sally Greengross, cross-bench peer and Chief Executive of the International Longevity Centre UK

Julian Le Grand, Richard Titmuss Professor of Social Policy at the London School of Economics

Experts by experience group

Eleni Chambers

Clenton Farquharson

Brian Gumbley

Heather Hughes

Becky Huxtable

Claire Jones

John Lish

Sally-Ann Marciano

Dominic Stenning

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The views expressed in this report are those of the independent commission and do not necessarily represent the views of The King's Fund.

Commission on the
Future of **Health** and
Social Care in England

A new settlement for health and social care

Final report

Chair
Kate Barker

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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Foreword

Background to the commission and the role of The King's Fund

The King's Fund established the Commission on the Future of Health and Social Care in England in 2013 to explore what a new settlement for health and social care might entail. The commission's interim report set out a compelling case for a new settlement based on the huge pressures facing the NHS and social care at a time of growing demands and constrained resources. These pressures, together with the complex needs of an ageing population, call for a response that goes well beyond patching up existing services and making the changes set out in the Dilnot report, welcome as the latter are. Nothing less than a fundamental rethink of how health and social care should be funded and provided is needed to create a system fit for the future.

The interim report argued that England needs to move towards a single, ring-fenced budget for health and social care that is singly commissioned and within which entitlements are more closely aligned. The report also outlined a wide range of options for funding a new settlement, including charges for health care, cuts in other areas of public spending and higher taxation. This final report sets out its recommendations on these hard choices, drawing on evidence received from stakeholders, further research and analysis, and deliberation among the commissioners. Under its recommendations, entitlements to social care would be fairer, more consistent and more generous, while entitlements to health care would be unchanged.

Importantly, the commission's analysis shows that higher public spending on health and social care is affordable if it is phased in over a decade. To be sure, higher public spending on health and social care will take up a bigger proportion of GDP, but with the economy also growing additional resources will be available for other public services. When fully implemented, the new settlement will account for around 11–12 per cent of GDP, a figure broadly comparable with current expenditure on health alone in some other countries. The commission recommends higher public spending should be paid for through tax and national insurance increases, reallocating funds from other areas of spending, and changes to prescription charges.

It may seem bad timing to propose higher spending when public finances are still recovering from the financial crash of 2008 and many public services face the prospect of further cuts. One of the great merits of the commission's report is that it rises above these immediate pressures, important as they are, to identify medium-term choices. There are no signs that private insurance products will emerge to cover the costs of care up to the Dilnot cap and this underlines the need for a predominantly *public* solution to care funding even though the major political parties seem unwilling to debate how this might be achieved.

The consequences of doing nothing are that fewer people will receive publicly funded social care as further cuts are made to local authority budgets and more NHS organisations find themselves unable to provide timely access to acceptable standards of care within budget. Even more importantly, the prize described by the commission

– equal support for equal need with entitlements to health and social care more closely aligned – will remain a distant dream. People needing access to care will be forced to continue to navigate the complexities and inconsistencies of the current fragmented systems of funding and entitlement described so vividly by the experts by experience who contributed to the work of the commission. The costs of this care will fall increasingly to individuals and families, creating worry, uncertainty and inequity on a scale that would be unacceptable were it to apply in health care.

The King's Fund is extremely grateful to Kate Barker and her fellow commissioners for their work in preparing this report. We shall be using their analysis and recommendations to engage with a wide range of stakeholders to explore the practical implications of implementation. This process of engagement is designed to ensure the debate on the future of health and social care is kept alive during the forthcoming election campaign and not consigned to the 'too difficult' basket. It is also intended to ensure that the consequences of the commission's recommendations are fully understood.

At the end of this process, the Fund will present its own views to the incoming government on the implementation of changes that should result in a system of care better able to meet future needs. The issues the commission has addressed could not be more important in deciding the kind of society in which we live and the care we are able to offer to some of our most vulnerable citizens. This report offers a firm foundation on which to build a better and sustainable system.

Chris Ham
Chief Executive
The King's Fund

Chair's overview

I have a social work qualification. I know how the health and social care system is supposed to work, but I was powerless... nothing was joined up.

Marie, social care planning manager

This story, and many others like it, prompted the conclusion in our interim report that the 1948 settlement for health and social care needed to be reconsidered urgently. We felt that, against today's needs, the settlement lacks transparency, is inefficient, puts too much weight on individual rather than collective responsibility and is not equitable. Most importantly, the present situation simply does not respond sympathetically to the needs and preferences of users and their carers. These considerations formed the criteria by which we have judged proposals for change.

Our contention was that this situation creates much distress and cries out for reform, although this raises a real question about resources and, in particular, affordability given the present condition of the public finances. But it is vital to remember that the costs of supporting those in need of social care do not go away just because they are not met from the public purse. So the two key issues this final report tackles are:

- how to create a system of care that works better and more appropriately for individuals and their carers
- how far social care costs should be funded by those in need and their families, and how far they should be shared across society (as we are committed to doing for health costs).

Any serious analysis concludes that demands for health and social care in England are increasing significantly. As the economy returns to growth and incomes rise, we are likely to want to spend more on health care in line with international trends. Technological and other medical advances will bring cost pressures. An ageing population will add to these – not so much because living longer raises costs in itself, but because there will be more elderly people with the number aged over 80 projected to double in England by 2037. Lastly, there are already demands for a better standard of social care (and for a better-paid social care workforce).

In the interim report we described our vision as a single, ring-fenced budget for health and social care that is singly commissioned. This still seems to us the only way to tackle effectively the three present failures of alignment – around entitlement, funding and organisation. Our focus has remained very largely on entitlement and funding.

What is the commission's response to the considerable challenge set for us by The King's Fund?

A new pathway for users of health and social care

Our key concern has been to address the issues from the point of view of the users, and to design a simpler pathway to replace the current maze. What we lay out in more detail in this report is a pathway that starts from straightforward, non-means-tested help for

people with relatively low levels of need (in effect, currently provided by Attendance Allowance to be renamed a Care and Support Allowance) and moves through personal budgets that support personal care needs on to fully funded care for those with the highest needs, including at the end of life. However, we propose that accommodation costs are met privately for those in residential care, including those who would today qualify for NHS Continuing Healthcare. Under this system there would still be some element of means testing for the personal budgets, up to the point where needs are currently defined as critical or substantial. This would mean a simpler and more transparent system, with far greater equality of treatment between those with different types of ailment – the example of the differences in funding for patients with cancer and for patients with dementia remains potent.

To fund this we would propose putting together the existing budgets for Attendance Allowance, local authority funding for social care and much NHS expenditure. However, these budgets would unquestionably need to be larger, despite potential for savings arising from a more integrated system. This is partly because the evidence for financial savings from integration is at present scanty. But also – and more importantly – the greater efficiencies should be used to ensure a better and more responsive system for users. That vision will not be cost-free; the pathway we propose will be more generous and will imply greater sharing between those who need social care and those who do not in a way that the commission considers to be a sign of a more civilised society.

Funding a 21st-century system

We share the views of the many commentators who believe that there needs to be a strong and continuing focus on NHS productivity. However, even if this is more successful in the future than it has been in the past, we consider that the current projection for the share of gross domestic product (GDP) absorbed by the NHS over the next few years is unrealistically low. In considering what the call on the public purse will be, we have therefore assumed a rate of real spending growth lower than the average from 1948 to 2010, but higher than the current projections from the Office for Budget Responsibility (2014).

This, together with the rising numbers of older people, leads us to conclude that additional funding, public or private, will be needed. Following the work of the Dilnot commission, there was an expectation that the insurance industry would respond with products enabling a private financing of care needs. However, this has not so far occurred.

The estimates presented in this report suggest that an additional £3 billion will be needed initially to make social care free for those regarded as having critical or substantial needs, rising to £5 billion by 2025. It should be noted that even with no change in entitlement, spending on social care is estimated to rise by £3 billion from present levels by 2025.

An argument against seeking this money from the public purse is that many of those who would benefit could afford to pay. That is also true for health care, although the same argument is rarely made in that case. However, even under our proposed settlement much support for those with moderate needs will continue to come from families and voluntary groups – and the risk of rising public costs will be contained by the setting of personal budgets. Under our proposals, some of the extra public funding will be raised from the better-off older population, so the costs will be shared more fairly between those who develop high social care needs and those fortunate enough to have few or none.

There are a number of possible ways to fund this additional public spending. Some of these have been considered carefully by the commission but are not included in our recommendations. These include: social insurance pre-funding and, at least for the present, earmarking some elements of taxation (hypothecation in economic jargon).

We do, however, favour a new independent body to make recommendations on the public spending requirements for health and social care.

We looked hard at the question of introducing new charges into the NHS. However, most options for charges seem likely to raise administrative problems and the risk of adverse impacts, which make them unattractive.

Given that we are seeking to spread the burden of care more fairly, and given that on average the present generation of pensioners is relatively well off (both compared to past pensioners, and to the likely prospects for the present generation under 40), it seems right that many of the tax and other changes we propose should, at least initially, affect this group. However, the 2.5 million people on pension credit will be very little affected.

We are proposing that the winter fuel payment and free TV licence, which are presently based purely on age, should be means tested. Additionally, National Insurance at a reduced rate could be levied on those who work past state pension age. These measures, in addition to the tax changes proposed to fund the Dilnot reforms, should be sufficient to meet the short-term costs of the new settlement.

However, as the numbers of older people increase, if standards and entitlements are to be maintained or improved in health and social care, more revenue will be needed. In addition, the extra pressures from rising health costs will need to be met. We make two suggestions to close this gap, although clearly there are others. The first is a review of wealth taxation, including inheritance tax, which is too frequently avoided. The second is a package of increases in National Insurance, affecting those over 40 (who will be considerable beneficiaries from the new settlement) and the higher paid.

Increases in charges, loss of benefits and higher taxation are all unpopular. But as the individual social care burdens rise, these will increasingly be seen as more equitable ways to shoulder these burdens.

A continuing debate

It is all too clear that, while we have tackled these knotty issues with resolution, questions remain about exactly where some of the funding lines should be drawn, many details need to be filled in around the pathway and commissioning, and further work on sources of revenue is required. And it is apparent that England cannot move to this new settlement quickly – it will need to be done in stages and so we make some suggestions for prioritising our reforms. We also note that, since our interim report was published, other suggestions for reform have been made. We remain convinced that these issues cannot simply be ignored. Over the coming months, we would want these proposals to help to shape the wide debate that is needed. But of course our ambitions run beyond a debate. It is vital that England moves forward to health and social care pathways that are formed around the individual and respond better to their preferences. More generous public funding is needed if we aim to be a civilised 21st-century society. Even without greater generosity, a public finance challenge is looming. Politicians of all parties cannot put off this challenge, nor can they ignore the human cost of the present system.

The prize of our new settlement is huge: a more integrated service, a simpler path through it, more equal treatment for more equal need, and a far less distressing experience for those trapped in the confusions of today's arrangements.

I am very grateful indeed to my fellow commissioners for their patience, wise counsel and engagement in sometimes heated debate. It has been a privilege to work through these difficult questions with such a wealth of experience in the room.

Kate Barker

1 The key issues we have identified

Summary

- A much simpler, graduated pathway of support is needed through the current health and social care system.
- Far better integration of health and social care is also required so that services are built around people's needs – not around the current definitional divides of health and social care.
- To achieve that, England needs to move to a single, ring-fenced budget for health and social care with a single local commissioner.
- There should be more equal support for equal need.
- Attendance Allowance is closely related to the social care system.

The current arrangements for health and social care in England were essentially laid down in two mighty pieces of legislation in 1946, almost 70 years ago. Both took effect in 1948.

The NHS Act created the National Health Service, a comprehensive system of health care, open to all, and almost entirely free at the point of use. In the words of Aneurin 'Nye' Bevan, its creator, it 'lifted the shadow of fear from the homes of millions'. What we now describe as social care was covered by the National Assistance Act. It legislated for the National Assistance Board and for local authorities to make provision for the welfare of 'disabled, sick, aged other persons'. It claimed in its preamble to have 'terminated' the existing Poor Law.

Although this was a step forward, in practice the Poor Law continued to cast a long shadow. What we now call social care remained heavily needs- and means-tested. Individuals have to pass tests of eligibility – thresholds of need for support – to qualify for publicly funded social care. They must have relatively little income and few assets to receive their care entirely free, particularly when they move into a residential or nursing home. These days much of social care – indeed more than half of it – is currently paid for privately. The successor to the National Assistance Board, the Department for Work and Pensions, still separately pays out benefits for people with disabilities and their carers, while the range of such benefits has increased significantly since 1948.

In the 66 years since these two landmark pieces of legislation took effect there have been huge social, demographic and technological changes. Medicine has been revolutionised. Younger people with one or more disabilities who would have died as children now live fulfilling lives as adults. Life expectancy has rocketed and is projected to go on rising. Greater longevity combined with the 1940s and 1960s 'baby booms' mean that the numbers living on past state pension age, and living for much longer when they do, have been rising steadily and will now start to rise very fast indeed. The pattern of disease has

also changed, almost beyond recognition. The NHS now not only provides treatment and cure but enables people to live on with chronic conditions. Diseases of old age, such as dementia and Parkinson's disease, rare when life expectancy was much shorter, are now much more common.

There is much to celebrate in all this. On average we are living longer and fitter, not longer and sicker. But the changed pattern of disease and the sheer increase in the numbers of older people mean that there are many more frail older people who live with multiple conditions that require either health or social care or, very often, both. There are also many people of working age to whom the same applies. Population projections suggest that the numbers of older people needing care will continue to grow significantly – the number of people aged over 80 is expected to double to 6 million by 2037.

All that has led The King's Fund to argue for some time that it is 'Time to Think Differently' about the way health and social care services are delivered and paid for. Last year they asked the Commission on the Future of Health and Social Care in England to revisit the 1948 settlement and ask if it is still fit for purpose 66 years on.

The interim report

Our interim report in April 2014 set out in much more detail the background outlined above and the changes to the boundaries between health and social care that have taken place since 1948 ([The King's Fund 2014a](#)).

It opened with three real-life accounts of what it is like to struggle with the existing system of health and social care in England. Two of those are reproduced here ([see pp 10–12](#)) to illustrate in part what the effects would be of the recommendations that we make in this final report.

Provided by our panel of experts by experience, those moving and powerful accounts of just how dysfunctional the current arrangements can be have driven us, along with much of the other evidence we received, to the conclusion that England does indeed need a new settlement for health and social care – and that the current one is no longer fit for purpose.

The fault lines between health and social care affect people of all ages, with serious issues of integration *within* health care as well as *between* health and social care. But they are perhaps illustrated most acutely, as in the accounts we include here, in the battles over what is known as NHS Continuing Healthcare – where an individual's combined health and social care needs are so complex and intertwined, and at such a high level, that the health service continues to provide all care for free, in place of means- and needs-tested support. Whether or not people qualify for that has big financial implications, both for families and individuals, and for the health and social care systems as this determines who should pay for what. The assessment also has a big emotional impact, as the case studies from our experts by experience illustrate.

Our interim report made the diagnosis that in today's changed world three problems in the current arrangements have come to plague us.

A lack of alignment in entitlements to health and social care. The NHS remains largely free at the point of use. Social care is both heavily needs- and means-tested. As these entitlements stand they create inequalities that the commission believes are profoundly unjust.

A lack of alignment in funding streams. The NHS, broadly speaking, is paid for out of general taxation and operates within a ring-fenced budget. Social care is paid for either privately or from non-ring-fenced local authority budgets. Councils retain considerable discretion over how much is actually spent. Who pays for what is a source of constant

friction between the NHS and social care, with enormous and distressing impacts on the patients, users and carers caught between the two.

A lack of alignment in organisation, with health and social care commissioned separately.

To tackle these three structural flaws, we argued in our interim report that England needs to move over time to a single, ring-fenced budget for health and social care that is singly commissioned.

Other problems with the current settlement

The diagnosis too often determines the financial support received

The NHS introduced health care for all, free at the point of need and regardless of income. But in the current settlement the diagnosis you have in large measure determines the financial support you receive to cope with its effects.

In the 21st century, it is simply not acceptable that people with conditions that can involve very similar burdens – cancer and advanced dementia, for example – end up making very different contributions to the cost of their care. That led us in our interim report to recommend that entitlements should be more closely aligned and that there should be more equal support for more equal need.

NHS Continuing Healthcare

Whether an individual qualifies for NHS Continuing Healthcare is in effect an ‘all or nothing’ assessment. Pass the assessment and all health and care, including accommodation costs, become free – up to the assessed level of need and up to the limit that the NHS and social care will pay for accommodation. Fail it, and the means tests kick in for both care and accommodation, with large financial implications for those who do not qualify. Those judged not to be entitled may – subject to a separate assessment – be entitled to registered nursing care, a payment towards nursing care costs in a nursing home. Passing or failing the Continuing Healthcare assessment has too many parallels with winning, or not winning, a lottery. It creates much friction between the NHS and local authorities over who should pay. It requires a significant bureaucracy that includes appeals and an independent review mechanism often involving lawyers. There are wide regional variations in who qualifies and who does not (*The King’s Fund 2014a*, p 18). NHS Continuing Healthcare currently costs the NHS approaching £3 billion a year and rising, with some 60,000 people receiving it (*Hansard (House of Lords Debates) (2013–14)*).

A market failure in social care

Following Sir Andrew Dilnot’s report into social care funding, reforms introduced by the Care Act 2014 will, from 2016, start to cap the lifetime costs to the individual of the assessed need for social care at £72,000 (*Commission on Funding of Care and Support 2011*). It is important to note that the cap applies only to *eligible* needs – that is, those that a local authority assesses to be necessary. The guidance that will go with this reform is still subject to consultation. But it looks likely that those needs will broadly correspond to ‘substantial’, the second highest of four categories of care that local authorities presently use, which stretch from ‘low’ through ‘moderate’ to ‘critical’. In addition, these costs will only be based on what the local authority would pay for that level of care. That will in many cases be less than the amount currently paid by people not entitled to publicly funded care. As *The King’s Fund* said in evidence to the House of Commons Health Select Committee in 2013, there is a high risk of ‘confusion, complexity and complaints’ occurring once that becomes clear (*The King’s Fund 2013*).

Even with the cap in the Care Act and the more generous means test that goes with it, people will still be making a financial contribution towards their social care that would be unthinkable if it were applied to health.

It is sometimes argued that the heavy means testing of social care is in fact equitable, since the principal beneficiaries of any more generous system would be the inheritors of that individual's estate. But this implicitly assumes that social care is only provided to those close to death, which is far from the case. Only around half of social care spending goes on those aged over 65. Moreover, as we noted in our interim report, the same argument could be used to justify the heavy means testing of health care: a policy that few would endorse.

It was hoped that the cap on lifetime costs would allow an insurance market to emerge to help cover the significant costs that people will still have to meet. But there are very few signs of that happening. Since our interim report there have been further discussions between health ministers and the insurance industry, and further promises of best endeavours ([Department of Health and Association of British Insurers 2014](#)). But the insurers show little appetite for producing the new products that would be needed. That market failure suggests to us that there will need to be more public intervention if our goal of more equal support for equal need is to be met.

A new, simpler pathway is needed through the current arrangements

Since our interim report we have become increasingly aware of the role played by cash benefits from the social security system for people with disabilities and care needs. These include Attendance Allowance, paid to those aged over 65, and Disability Living Allowance (DLA), which goes to adults aged under 65. DLA is currently being replaced by the Personal Independence Payment (PIP). In addition, there is Carer's Allowance, and Employment and Support Allowance. The latter is essentially a sickness benefit but when paid at the highest level, to those not expected to prepare for work, it has some overlap with the intentions behind DLA/PIP.

We have focused on Attendance Allowance, which, while not usually considered as part of the social care system, is clearly closely related to it. It is paid to those who need frequent help or constant supervision, and the eligibility criteria for it have marked similarities to those for social care – ie, the need for support in activities of daily living such as preparing food, eating, washing, dressing, going to the toilet and medicines compliance, and whether someone is a risk to themselves or others.

It acts in many ways like the personal budgets that have been widely adopted in social care and which are now to be extended into joint health and social care personal budgets ([NHS England 2014b](#)). Attendance Allowance adds, however, a further twist to the maze of support offered in health and social care.

Under the present arrangements, support is provided at different times, and sometimes concurrently, by the Department for Work and Pensions via Attendance Allowance, by local authorities through domiciliary and residential and nursing home care, and by the NHS through registered nursing care and Continuing Healthcare. Although Attendance Allowance in general supports lower levels of need, it can be claimed without the usual waiting period where someone is judged to be terminally ill.

These disjointed approaches create complexity, perverse incentives and confusion, and they increase the stress on families and individuals, particularly when their needs are highest and towards the end of life. It makes no sense that these three elements of care and support operate in such separate silos.

So, in addition to the recommendations in our interim report, we believe that it is essential to devise a much simpler pathway through the current arrangements.

In the next chapter we set out how the new settlement should work. **Chapter 3** provides estimates of what that might cost at varying levels of generosity. **Chapter 4** asks how far that is affordable, while **Chapter 5** makes recommendations on how it can be funded. The final chapter draws together the commission's recommendations – which are highlighted in bold throughout the report – and summarises both the prize to be gained and some of the problems still to be solved to get to this new settlement.

2 The new settlement

Summary

- The new settlement breaks down the current divides between health and social care.
- It is simpler to understand and navigate.
- Attendance Allowance is brought within it to contribute to a more graduated pathway of support.
- It provides more equal support for equal need by making personal and social care free at the highest levels of need, starting with critical needs.
- Increasingly it offers personal budgets and more support to promote independence.
- It operates within a single, ring-fenced budget, with a single local commissioner, offering one point of contact in place of three.
- It increases, through the single budget, the opportunity for integrated services.
- It provides better value for money.

England needs a new settlement for health and social care that breaks down the historic divide between the two and produces a much simpler path through the current maze of health and social care (Recommendation 1).

To help achieve that it needs to move to a single, ring-fenced budget for health and social care, with a single commissioner (Recommendation 2).

As we have noted, Attendance Allowance is very closely related to social care and acts like a personal budget. So to help create the simpler, graduated pathway of support that we seek, **we believe the time has come for Attendance Allowance to be brought within the health and social care system (Recommendation 3).**

In our new settlement lower levels of need would be met through a new cash payment called the care and support allowance. This would be modelled on the current Attendance Allowance and be available on much the same basis – in other words, it would not be means tested or taxed, and entitlement would be based broadly on the same criteria. These payments should come with active support to restore as much independence as possible, thus reducing the need for financial and other support. Elements of such an approach, which we applaud, are already being adopted by many local authorities as they seek to make the most of their cash-constrained social care budgets ([Local Government Association 2014b](#)).

As the individual's needs rise, a more thorough assessment would be required, with further help available through a formal personal budget.

Once the need for support falls within the parameters that the social care system currently defines as critical or substantial, all care should become free at the point of use, although still subject to an assessment of what those needs are and how they should be met.

As we explain later in the report, we believe that this new settlement will need to be phased in. But even a first step towards it – making critical care free at the point of use – would begin to provide the **more equal support for equal need** that we seek, and would have the effect of ending the current distinction between NHS Continuing Healthcare and social care. We would stress that our recommendations would apply to new recipients of Attendance Allowance, not to current ones. Nor do we recommend cutting the level of financial support that Attendance Allowance offers.

But bringing it within the settlement will help create a simpler, more graduated path through the current maze of the health, social care and benefit systems. Making personal care free at the highest levels of need will end the current 'all or nothing' distinction that NHS Continuing Healthcare provides.

This new settlement will not undermine the role of families and carers. They will still play a significant role at the lower levels of need, while being relieved of much, though not all, of the burden as needs become greatest, particularly towards the end of life.

Our recommendation that there should be a single local commissioner for the new single budget does raise the question of who this should be. We have not had time to explore that in any detail, although, as we said in our interim report, a sterile debate should be avoided over whether health should take over the commissioning of social care or whether local authorities should commission the NHS. We do note however, that a number of others, including the House of Commons Health Select Committee, have said that over time the new health and wellbeing boards could evolve into a single commissioner for health and social care locally. That idea has its attractions. **We recommend that work be undertaken to explore whether the health and wellbeing boards could evolve into the single commissioner for our new settlement (Recommendation 5).**

Accommodation costs

As part of our review of the current arrangements we have also looked at the way that accommodation costs are currently handled. We believe that outside hospital – which is where NHS Continuing Healthcare overwhelmingly takes place – the cost of accommodation should be treated more consistently.

Those receiving care at home already pay for their accommodation, or have it met through housing benefit. Those in residential and nursing homes currently meet their accommodation as well as their care costs until their resources are reduced to the level where they qualify under the means test. Under the Care Act 2014 that will continue to apply up to an annual cap of £12,000 a year, the equivalent of around £33 a day. By contrast, those who receive NHS Continuing Healthcare have all their costs, including the accommodation cost, met.

The Dilnot commission highlighted the unfairness of one resident in a nursing home having to pay for their accommodation when another, with remarkably similar needs, does not pay because they receive NHS Continuing Healthcare. To help provide more equal support for equal need, and on the grounds of transparency and equity, **this commission therefore recommends that new recipients of what is currently defined as NHS Continuing Healthcare should meet their accommodation costs**

(**Recommendation 6**). This will release a small sum to help meet the very considerable costs of our new settlement. It will involve losers among a new generation who would have had all their costs covered. But there will be many more gainers from our recommendation that all care should become free at the point of use at the highest levels of need.

Below is a purely illustrative diagram of what the new settlement would look like. It cannot be introduced overnight. Getting to the final, fully implemented version is likely to be a journey of a decade for reasons we spell out later in the report. But it is where we ought to be.

Table 1 Towards a graduated path for health and care support

	1	2	3	4
Description	Low An individual is able to live independently but may have some needs that can be met through cash support only (unlikely to satisfy existing local authority eligibility criteria)	Medium Needs some help with daily activities through care package at home; health care provided through primary care	High Level of needs requires a high level of personal care with a significant health as well as care input; for many these needs can only be met in residential, nursing or extra care settings; or through a very intensive package of care at home	End-of-life care Very intensive mix of personal care, clinical and palliative care at home or in hospice
How would support be offered?	Cash payment akin to the current Attendance Allowance	Personal budget through direct payment or managed budget which may not meet all costs	Directly commissioned service or enhanced personal health and care budget	
How would needs be assessed?	A simple screening process to establish whether there is a broad entitlement; signposting to other services; enablement work to support/ restore independence	Basic assessment of care and support needs and enablement to support/ restore independence and reduce costs	Comprehensive, multidisciplinary assessment that could involve a range of health and care professionals	
How would services be commissioned?	Self-commissioned	By local integrated commissioning function, with individuals involved in their care plans and spending decisions wherever possible		
How would the single local budget be made up?	A single local budget comprising: <ul style="list-style-type: none"> ■ the existing Attendance Allowance spend (Department for Work and Pensions) ■ the NHS budget for clinical commissioning groups, including primary care, Continuing Healthcare, the registered nursing contribution and other special placements ■ local authority social care budget for home care, residential and nursing care 			
Who would pay for what?	Individual would meet costs of accommodation in all settings outside hospital Met directly by individual with cash payment	Met directly by individual with help from local authority subject to financial assessment	All personal care – irrespective of whether it is ‘health’ or ‘social’ is free at point of use	

The prize

This new path for health and social care, combined with the single ring-fenced budget and a single commissioner, and the provision of more equal support at the highest levels of need offers, we believe, a huge prize. Patients, users of care and support and their families would face a much simpler path through the current maze of cash benefits, health and social care. Support would begin with cash payments that contribute towards the costs of care and would rise as those needs become greater. But there would be more support than there is now to help people live as independently as possible – a move that should both improve their lives and constrain costs, allowing the budget to go further. As care needs become greatest, both health and social care would become free.

Personal budgets, and care in hospital and out of it, would be provided from a single, ring-fenced budget. There would be one budget and one commissioner for individuals and their families to deal with, in place of health, social care and, in the case of those aged over 65, the Department for Work and Pensions. Commissioners would be freed to acquire care designed around an individual's need for support and health care, largely dissolving the current definitions of what is a health need and what is a care requirement.

The single budget and single commissioner would offer the opportunity to provide many more integrated services, working out with individuals what their needs and preferences are and making it easier over time to provide services in the place where they produce the best results – whether that is at home, in residential and other settings, or in hospital. This would bring big gains not just for older users of health and social care services but also for younger ones. It would help those who use services as well as those who commission them to pursue broader aims such as genuine parity of esteem between mental health and physical health – something that must become much more than just a slogan.

There is already good evidence that integrating care in this way produces better services and a better experience for care users and patients (Thistlethwaite 2011; Bardsley *et al* 2013; Timmins and Ham 2013), and in time we believe that it must lead to better value for money.

We fully acknowledge that a single budget with a single commissioner by no means guarantees better integration of services – it is the lack of integration *within* health, as well as *between* health and social care, that is one of the prime sources of complaint in the broader evidence we received and in the accounts from our experts by experience.

But, with individuals gaining increasing control and having an increasing say over what is provided, where and how, single commissioning does offer the opportunity to achieve better integration in ways that are likely to be far more powerful than the current attempts to pool budgets between health and social care. Moving to a single budget with a single commissioner is not a *sufficient* condition to tackle the myriad problems of integration that face health and social care. But we believe it is a *necessary* one.

A short note on a matter we considered, but where we did not make a recommendation

As we mapped the way to this new settlement, the recommendation that Attendance Allowance be brought within it inevitably raised questions about what should happen to DLA/PIP – the equivalent cash benefit for adults below the age of 65.

The case for a simplified pathway is just as compelling for working-age adults as it is for older people. Simple policy logic would suggest that DLA/PIP should be brought within this new system. The issue, however, is less clear-cut than with Attendance Allowance. Far more than for older people, where Attendance Allowance is claimed as health declines and the need for social support grows, DLA/PIP is regarded by its recipients as helping to meet the costs of living with a disability; one that will be with them throughout their adult life, from whatever point their disability made them eligible. As SCOPE has pointed out, these are substantial – disabled people spend on average £550 per month on costs related to their disability (SCOPE 2014).

Furthermore, the change we recommend for Attendance Allowance is a large-scale one in its own right. The already controversial move from Disability Living Allowance to the Personal Independence Payment is still under way. It will not finally be completed for several years, and bringing these benefits into our new approach would thus be an extremely hazardous operation. We therefore do not recommend such a change at this stage. However, when the new settlement is established, further work should be

undertaken into whether it would make sense to bring cash benefits for those of working age into the new settlement in the way that we propose for older people.

Before turning to what this new settlement might cost, we illustrate in the boxes below what it would mean for two of our experts by experience.

Ray's story, as told by his daughter Sally-Ann

My father, Ray, who suffered from dementia, was admitted to hospital with pneumonia 11 weeks before he died. He was already known to social services with a care package in place, so we thought the process for discharging him would be pretty straightforward – how wrong we were!

He could not be left unsupervised as he was unable to do anything for himself. He was at risk of malnutrition, dehydration and pressure sores and prone to recurrent infections. None of this seemed to be defined as a health need, and it took five weeks to reach a decision about whether he was entitled to NHS Continuing Healthcare as health and social care fought over who should pay. Where was the person in all of this?

It was decided that he didn't qualify. But then began our next battle. Dad's care package had to be arranged through the hospital's social services team which meant that he could no longer have the care agency he had been using for the previous two years – which had given him the same carer every morning for five days a week. She had become like part of the family. The carer becomes part of your life – the first person you see after a sleepless night and the one who is always there for you day in and day out. For my mum, this was a huge blow. They were taking away the only familiarity and support they both so needed at this time. Mum felt like a stake had been driven through her heart. Her beloved Ray was dying and her carers were being taken away too. Bear in mind that the monthly bill for my dad's care was running into four figures.

The community nursing team even tried one last attempt at getting NHS Continuing Healthcare funding for Dad and even 24 hours before he died they turned him down. A visit once a day to change the pump, and a night-sitter for his last three nights was the health-funded contribution. What I now ask is: why should anyone at the end of their life have to pay for their own care to die at home?

So what would be different if our recommendations were implemented?

A big source of distress for Ray and his family was the traumatic process of the Continuing Healthcare assessment to determine whether his needs were a health or social care responsibility.

Under our proposals Ray's needs would be deemed 'high' ('critical' under the old system) and so all his care would be free at the point of use. This would relieve his family of worrying about a care bill that ran into four figures each month. The purpose of the assessment would be to establish how his needs could best be met – not to determine whether the family or the NHS should pay. Everyone's energies could then be concentrated on making sure that Ray got the care he needed.

The need to change the team of carers disrupted Ray's care and caused distress to his family. Our proposal for a single local commissioner would help to streamline the process of arranging services so that it would no longer be fragmented between different teams and organisations. Sally-Ann has emphasised to us the importance of not setting the threshold for free care so high that few people would benefit.

Clifford's story, as told by his daughter Becky

Clifford is 77, very physically fit but has no cognitive understanding. He can be very difficult. After a very distressing emergency admission on to a mental health assessment unit, it was decided that he couldn't go back home with Mum. Dad was assessed for NHS Continuing Healthcare [CHC] funding – full funding by the NHS. This was declined.

His needs are complex and there were no care homes in my parents' area which could meet all of Dad's assessed needs for the amount that the local authority was willing to pay. The only home that agreed to take him was 22 miles away from Mum. In order to get there, my 73-year-old mother would have had to spend 2 hours on a bus, each way, changing 3 times on each journey. By attempting to place Dad further and further away from family and friends simply due to cost, his assessed need for family contact was not being met. I made a formal complaint to the county council's head of consumer relations, and also to the head of legal services. Dad was reassessed for CHC and was granted it. We were obviously pleased with this result... but we couldn't understand why, only six weeks earlier, he didn't even meet the basic criteria.

Dad was subsequently placed in a home 4 miles away from where he has lived for 50 years, and where family and friends can visit him easily; he is visited around 4 to 5 times a week. I know that if I hadn't fought this, Dad would now be in a home 22 miles away from family and friends, with perhaps visits once a week.

I could see the same situation happening to others on Dad's ward, and I was appalled by the whole system and the way in which Dad was let down by his care co-ordination team.

But since the interim report was written there has been a further twist. In August last year his CHC funding was removed – as his behaviour was less aggressive, apparently making his care not as difficult – or in the jargon 'was not of an intensity and complexity to require CHC funding'. But he still needed a very high level of care – he was doubly incontinent, had to have all needs anticipated, was totally immobile, had bed sores and needed 24-hour nursing and care. We began our appeal in September and now await the outcome of the hearing held in July. This has created fresh worries about being forced to move him to a different care home that would cost less than his current one – or having to pay a 'top-up' fee to keep him where he is. So far no other home is willing to take him because his needs are so high. Most of Dad's pension is now going towards his care home fees, along with a local authority contribution.

This underlines the importance of funding social care more generously to provide the right care in the right place.

So what would be different if our recommendations were implemented?

Under our proposals Clifford's needs would be deemed 'high' ('critical' under the old system) and so all his care would be free at the point of use. This would recognise that the needs of people with dementia and other conditions can fluctuate and go backwards and forwards across the health and social care boundary. He would not have required three different assessments and his family would have been spared the time, stress and cost involved in battling against earlier decisions. Clifford would still need to meet the accommodation element of his care home costs under our proposals – subject to the annual cap of £12,000 effective from 2016 – but this would be much less than the total bill that Clifford and his family have to find under the current system.

continued overleaf

Clifford's story, as told by his daughter Becky *continued*

Our proposal for making critical care free at the point of use would also remove the uncertainty and worry caused by the prospect of having to find a care home that could cater for Clifford's needs but at a lower cost than a Continuing Healthcare-funded placement. Currently he is in a home close to where he has spent most of his life and where friends and relatives can visit easily. His continuity of care is now threatened by the possibility that he might have to move, depending on the outcome of the appeal.

This underlines the importance of funding social care more generously to provide the right care in the right place.

3 Costing the new settlement

Summary

- Spending on social care, particularly for older people, is going to rise, regardless of whether it is funded publicly or privately.
- Making critical care free as a first step would initially cost substantially less than £3 billion a year.
- Making critical and substantial needs free at the point of use for older people, as a second priority, would cost approaching £3 billion initially and £14 billion by 2025 – some £5 billion more than currently projected expenditure.
- Making all care free down to moderate levels of need would cost £7 billion initially and more than £20 billion by 2025 – some £11 billion more than currently projected. This is more generous than our proposed settlement.

Costing this new settlement is not straightforward. To get an indication of what might be involved, the Personal Social Services Research Unit (PSSRU) has produced for us some illustrative projections up to 2025/6.

The two we have concentrated on are:

- making all social care at the levels currently defined as ‘critical’ and ‘substantial’ free at the point of use
- extending that to make ‘moderate’ needs free at the point of use.

In practice, even in 2005/6, ahead of the financial crisis when public provision of social care was at its most recent peak, not many more than half of councils met moderate needs ([The King’s Fund 2014a](#), p 10). But we have included it in the projections because free care down to moderate levels is what many in the social care sector would like to see. It is also an indication of the rising costs of care that will have to be borne across the population whether privately or publicly.

The first and second columns in Table 2, overleaf – the existing system and free care for critical and substantial needs – are modelled on the numbers getting publicly funded care through local authorities in 2012. The third column – free personal care for moderate needs and above – is modelled on the significantly higher numbers who were getting help in 2010 before the impact of spending cuts and other changes.

The projections strip out an element of accommodation or ‘hotel’ costs because we have recommended that those be applied more consistently on a means-tested basis. They cover only the additional costs for those aged over 65. There would be significant further costs for extending free social care for moderate needs to younger people with disabilities, though much less for only making critical and substantial needs free at the point of use

Table 2 Projected public costs of social care for older people excluding accommodation costs, 2012/13 prices

	The current system (£bn)	Free personal care for critical and substantial needs (£bn)	Free personal care for critical, substantial and moderate needs (£bn)
2014	6.07	8.83	13.02
2015	6.35	9.20	13.53
2016	6.55	9.58	14.09
2017	6.77	9.94	14.60
2018	6.89	10.30	15.15
2019	7.17	10.74	15.77
2020	7.45	11.24	16.48
2021	7.71	11.69	17.05
2022	8.00	12.19	17.75
2023	8.37	12.75	18.53
2024	8.86	13.49	19.59
2025	9.11	14.10	20.39

Source: Modelling carried out for the commission by the Personal Social Services Research Unit at the LSE.

as many younger people with disabilities already qualify for that under the existing means test.

A further qualification around these numbers is that although the Department of Health sets guidance on the eligibility thresholds for low, moderate, substantial and critical care (known as Fair Access to Care Services), their application is a matter of professional judgement. As a result, surveys show that there is significant variation in the way they are applied in individual councils across the country (Fernandez and Snell 2012). In addition, the definitions of eligibility will change under the Care Act 2014 in ways that have yet to be finally decided. These can therefore only be very broad-brush estimates of the potential additional costs.

What the modelling shows, however, in the first column, is that the current cost to the public purse of care for older people in 2014 is around £6 billion a year, excluding accommodation. Adopting our recommendation for critical and substantial care to become free at the point of use would add just under an additional £3 billion to current spending, if adopted immediately (second column, 2014 figure). That figure would rise to a little more than £14 billion by 2025/6 as against the projected forward cost of a little more than £9 billion for the current inadequate system.

Making all care free down to the current definition of moderate needs would more than double expenditure from £6 billion a year to £13 billion if introduced immediately (first and third columns, 2014 figure). That cost would rise to some £20.4 billion by 2025/6.

These projections come against the requirement, acknowledged by all the parties, to put the public finances on a sustainable footing. So our recommendation that critical and substantial needs become free at the point of use clearly cannot be introduced overnight. To extend free personal care for all down to moderate levels of need would involve an immediate spend of £7 billion, which is very roughly the equivalent to a rise of 2p in the pound for the basic rate of income tax (HMRC 2014). Given the current state of the economy we do not regard that as realistic.

Therefore **we recommend as an early initiative that what is currently defined as critical care should be made free at the point of use (Recommendation 4)**. Tackling critical needs would remove the current boundary battles around NHS Continuing Healthcare. As a first step, this would be a significant improvement for families and individuals where the need is greatest, and it would be an important step towards more equal support for equal need.

Substantial needs would then still remain means-tested, operating within the funding changes introduced by the Care Act. But the improved integration of health and social care delivery that we believe will flow from the single, ring-fenced budget, with a single local commissioner, should lead to a higher-quality service and an improved experience for those who fall into this category.

There are no robust figures – though there is some survey data – which break down spending between ‘critical’ and ‘substantial’ needs (Fernandez *et al* 2013). So it is not possible to calculate those costs with any precision. Nonetheless, it is clear that many fewer people receive support for critical care than for substantial needs. So the cost would be substantially less than the £3 billion cost of making both critical and substantial care free at the point of use.

As the economy recovers and the public finances improve, there will be a choice about what to do – use the proceeds of growth to pay down the national debt, to cut taxes or to raise public expenditure? There will, of course, be fierce competition for any additional public spending. But **we recommend that as a second priority, care free at the point of use should be extended to those with substantial needs (Recommendation 4)**.

However, there is a strong argument for extending some support for people with moderate needs, as otherwise the burden of this care will continue to fall on families, neighbours and the voluntary sector. This could be achieved in a variety of ways, for example, through a contribution towards costs, for example through an enhanced rate of our proposed care and support allowance, or by lowering eligibility thresholds. Decisions would be needed on how far that help should be means-tested or not. Such decisions are far enough off for it to be a matter for further debate. We have assumed, *pro tem*, that in whatever form this assistance came, it would remain means-tested.

So we recommend that some support should be extended to people with moderate needs by 2025, with the expectation that they would be expected to contribute to those costs subject to a means test (Recommendation 4).

4 Affording the new settlement

Summary

- The funding crisis in social care is worsening.
- NHS finances are deteriorating.
- England is not a big spender in either health or social care compared to other countries.
- Projections of current trends show that public health and social care spending will decline as a share of GDP up to 2025. We do not regard that as credible.
- As the economy grows it should be possible for publicly funded health and social care to take a larger share of the much larger cake.

We believe that we can afford to move some way towards our new settlement immediately, despite the present pressures on the public finances. Some of the funding changes we propose later in the report could be introduced now to achieve a more just sharing of the impact of illness and disability on people's lives. In the medium term a more generous system will still require some hard choices about taxation and some existing areas of public spending, despite the expected improvement in the overall economy. In the long term the choice could be made to provide some support for moderate levels of need.

But one point needs to be clear. So far as the public purse does not support these individuals, the costs of care, in time or money, will fall on them and their families. Individually, those costs are lower than when the needs are defined as critical or substantial. Jointly, those costs are high, as demonstrated in the LSE figures. The new settlement we propose does not remove all responsibility from individuals and their families, but it does share the most acute cost burdens more fairly across society.

Updates on policy and projected trends

There have been some policy changes since our interim report was published. These include the announcement that joint social care and health personal budgets are to be extended, and there will be changes to the way the Better Care Fund – the move to pool some £3.8 billion of health and social care budgets to achieve better integrated services – will operate.

There has also been some new information – including some good news. The Institute for Fiscal Studies has published a major piece of research supporting the analysis in our interim report that on average we are living longer and fitter rather than longer and sicker (Emmerson *et al* 2014; *The King's Fund* 2014a, pp 22–23 and pp 26–28). Key findings, on projections that run up to 2022/3, point to mortality rates continuing to improve, particularly for men, with more pensioners living in couples. The health of each cohort of older women is improving, with the proportion set to receive some form of social care falling. Employment rates for women in their late 60s, already at their highest for 40 years, are set to increase faster and approach or even overtake those for men in the early 2020s, with 37 per cent in work, alongside 33 per cent of men. Higher employment will see median income rise, and property wealth is projected to grow, with 75 per cent of single pensioners projected to be owner-occupiers by 2018/19 compared to 68 per cent in 2010/11 (Johnson 2013). However, income inequality will increase as those able to continue in work gain over those who cannot. Big inequalities in health status will remain.

Growing short-term pressures in health and social care

Since our interim report it has become ever clearer that both social care and the NHS are facing a mounting financial crisis. The Association of Directors of Adult Social Services (ADASS), in a survey to which 95 per cent of councils responded, warned that the present system of social care is becoming 'unsustainable'. During the past four years, more than £3.5 billion in savings have had to be found, with more to come (ADASS 2014). As we noted in our interim report, 26 per cent fewer people aged over 65 were receiving publicly funded social care in 2012/13 than were five years earlier, as were 24 per cent fewer younger disabled people (*The King's Fund* 2014a).

The Local Government Association (LGA) calculates that councils face a £5.8 billion shortfall by the end of the next financial year, including a £1.9 billion gap for adult social care. Sir Merrick Cockell, former chairman of the LGA, has warned that 'too many older people are being let down by a system which leaves them languishing in hospital beds while they wait for an alternative, or consigned to residential care because we lack the capacity to help them live independently'. The success of the Better Care Fund will be crucial, he said, to 'steer England's social care system away from the road to financial ruin. The stakes have never been higher' (LGA 2014a).

Meanwhile Monitor, the health regulator, has warned that, even after likely efficiency gains, the foundation trust hospital sector in England faces a £1.6 billion deficit next year. The King's Fund's quarterly monitoring survey of finance directors across all trusts shows that only 16 per cent are confident of achieving financial balance in the next financial year. Among the finance directors of clinical commissioning groups, only 30 per cent are either very or fairly confident of achieving that (*The King's Fund* 2014b). The Nuffield

Trust, working on unaudited accounts, has estimated that the NHS may face a £1.5 to £2 billion gap at the end of this financial year between the actual costs of running the service and day-to-day income (McKeon *et al* 2014). Furthermore, the most recent data also show that the NHS's waiting time admission targets are under growing pressure.

Room for growth in the longer term

These acute short-term pressures caused by deficit reduction and the need to restore the sustainability of the public finances are bringing to a head the question of whether the country is prepared to pay sufficient tax in order to support a decent health and social care system. They demonstrate the importance of being honest about the prospect of rising care costs for older people and the necessity of the radical new settlement we are proposing. In the rest of this chapter we explain why we believe that our new settlement is affordable in the longer term.

As people become richer they want to spend more on health and social care

We start with the analysis in our interim report showing that as countries become richer, they not only spend more on health, they also spend *proportionately* more – regardless of the degree to which health is publicly or privately financed. As they become richer, they choose to spend more on health, for reasons that are unsurprising, as the interim report spells out (The King's Fund 2014a, pp 30–32). It must also be true that as societies age they will also choose to spend more on social care.

England is not a big spender on health and social care

We now look at international comparisons, to set the United Kingdom's and England's spending on health and social care in a broader context.

In 2010, the latest year for which comparable international data are available, the United Kingdom spent 9.6 per cent of its national income (gross domestic product or GDP) on public and private health (Organisation for Economic Co-operation and Development (OECD) 2014). That is above the 9 per cent average for the European Union (EU) as a whole. But it is appreciably less than the 11 per cent or more spent by a number of countries with whom the United Kingdom may wish directly to compare itself, for example, France, Germany, Denmark, the Netherlands, Austria and Canada. In terms of purely public spending, the United Kingdom also spent around 1 per cent of GDP less than these countries – 1 per cent of the United Kingdom's GDP being, in today's terms, approximately £16 billion, or a little less than 16 per cent of the total UK NHS budget.

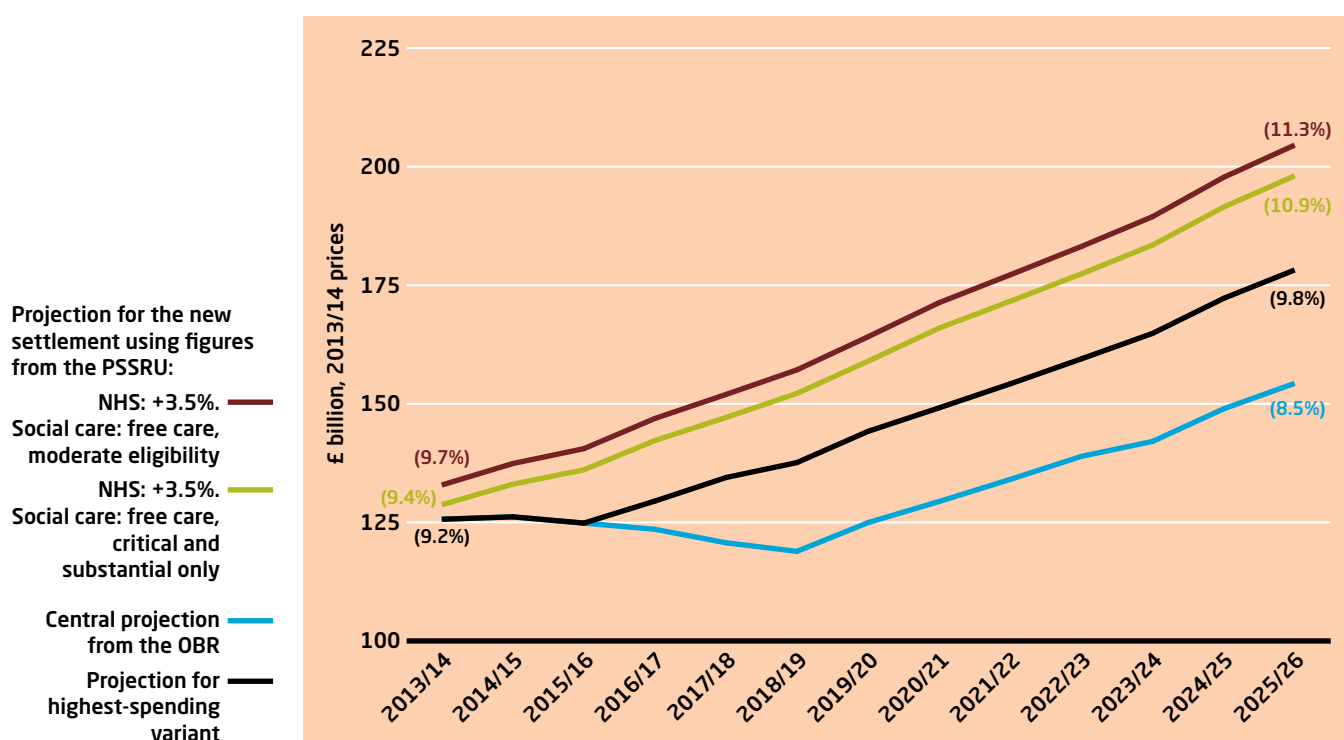
International comparisons of social care spending are fraught with even more difficulties than comparisons on health spending. The latest OECD data that includes the United Kingdom on comparable terms are available only for between 2006 and 2010. During that period, the United Kingdom spent on average around 0.9 per cent of GDP on what the OECD defines as public expenditure on long-term care. That is fractionally above the OECD average of 0.8 per cent. But it is appreciably less than in some comparable countries. The Netherlands spent 2.3 per cent, Denmark 2.2 per cent, Norway 2.1 per cent, while New Zealand, Canada, Belgium and France all spent 1.1 per cent of GDP or more. Most of those countries also spent an appreciably larger share of GDP on health. However, the UK figure for long-term care of 0.9 per cent of GDP has also to be compared against the 0.9 per cent spent in Germany, 0.7 per cent in Sweden and 0.5 per

cent in Spain (*The King's Fund 2014a*, pp 65–66). The little that can be gleaned from the figures suggests that spending in England and the United Kingdom is towards the lower end of the spectrum for comparable countries.

Higher spending looks affordable so long as hard choices are made

Figure 1, below, sets out projections for health and social care spending. The GDP figures have been estimated for England by taking the UK figures that the Office for Budget Responsibility (OBR) uses and simply adjusting them for England's population-based share of GDP. More detail of what lies behind these calculations is in Appendix B.

Figure 1 Projections for health and social care spending in England: 2013/14 to 2025/6



NB: Figures in brackets = spending as a percentage of England's share of UK GDP

Source: King's Fund calculations based on OBR and PSSRU data

The figure illustrates three things.

The blue line is the central projection from the OBR for spending on health and long-term care in England (adjusted from UK projections) on current policy and demographic assumptions. This assumes that NHS spending reduces in real terms by around 1.7 per cent per year from 2013/14 to 2018/19, before growth of around 3.4 per cent a year returns. For social care the assumption is an annual real increase of around 4.2 per cent from 2013/14 to 2025/6, though with a real-terms cut of 6.5 per cent in 2015/16.

The black line shows the OBR's projection for its highest-spending variant, which assumes growth resumes next year at an average rate of around 2.7 per cent a year for health and social care combined.

The green line projects costs based on our recommendations that critical and substantial care should become free at the point of use, using the figures provided for us by PSSRU.

For those aged over 65 we have used the unit's projections from Chapter 3. For younger adults we have used the OBR's high-spending variant projection.

We have also had to make some assumptions for increased NHS expenditure in order to get to a likely share of GDP being spent on health and social care combined. This is a matter of considerable judgement. Between 1948 and 1999, NHS expenditure in England increased by an average of 3 per cent a year in real terms, though with wide annual variations in that figure. By the end of the 1990s, however, the NHS was clearly under severe pressure. People were dying on waiting lists. The Wanless reports of 2001 and 2002 calculated that compared to the EU average, the NHS had underspent cumulatively by between £220 billion and £267 billion in the quarter century up to 1998. It concluded that 'not surprisingly, with such significantly lower spending, the UK health service outcomes have lagged behind continental European performance'. A period of 'catch up' was needed to restore services (Wanless 2001, 2002). That saw real spending increases of 6 to 7 per cent a year during much of the 2000s, taking the long-term real-terms average expenditure increase between 1948 and 2010 to just under 4 per cent annually. Given there has been a period of 'catch up' followed by a sustained real-terms squeeze since 2010, we have simply split the difference, assuming a 3.5 per cent annual real-terms rise in NHS expenditure to provide an idea of where NHS spending in England might reasonably go. To meet rising costs from medical advances and rising demand, such growth would still imply the need for a remorseless focus on NHS productivity.

The brown line provides a projection on the same basis, but illustrating what the cost would be if all social care were made free down to moderate levels of eligibility.

We make three observations about the numbers shown in Figure 1. First, the blue line shows that if NHS and long-term care spending reduces in real terms, as the OBR projects until 2018/19 – before real-terms growth resumes – then by 2025 England will be spending a smaller share of GDP than today. The commission simply does not find that credible given the impact of the ageing population, the return of economic growth, continued technological advances and rising public expectations of what a decent health and social care system should provide.

Second, the black line simply projects forward current policy on social care – in other words, where spending would get to with a publicly funded social care system that is becoming a residual service, increasingly available only to those with the heaviest needs and least means (The King's Fund 2014a, p 5).

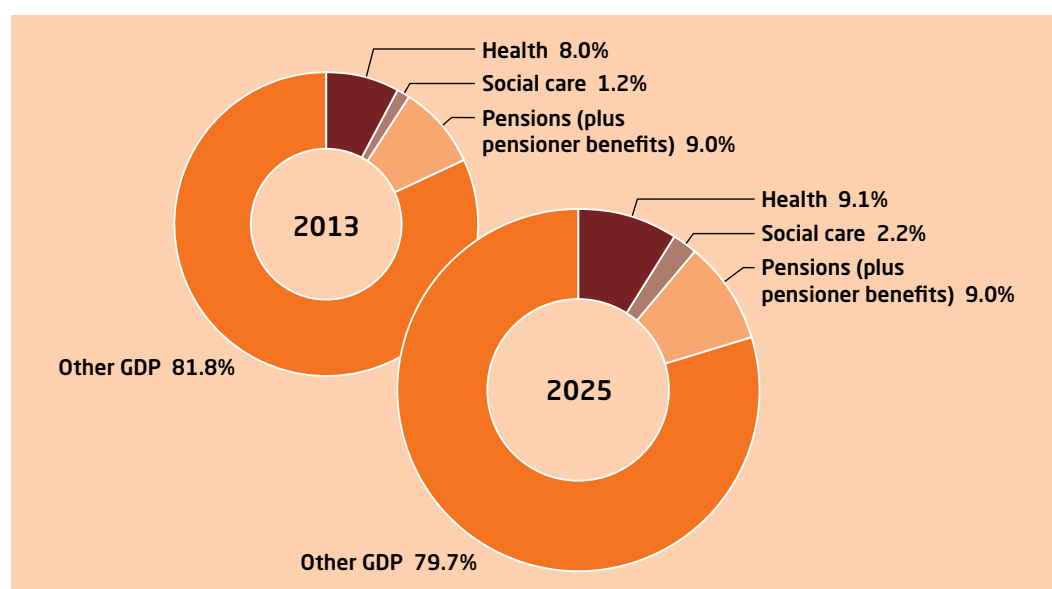
Third, if spending on health and social care combined is to reach 11 per cent or more of GDP by 2025, some hard decisions will need to be taken on taxation. However, it is important to note that, even in the highest of these projections, which includes all social care down to moderate being provided free at the point of use, public spending on health and social care combined totals some £126 billion out of a total English economy of around £1,365 billion in 2013/14. By 2025 that would have risen to £204 billion but in an economy projected to have grown to just over £1,800 billion. So the additional public spending accounts for less than one-fifth of the benefits of additional growth.

Health and social care would take a larger share of an even larger economy

What the figures show, in other words, is that public spending on health and social care would be taking a larger share of the country's income. But it would be a larger share of a much larger cake. The economy would be around more than one-third bigger, and that would still leave more money in real terms to spend on other things.

Health and social care spending is not, however, the only expenditure affected by an ageing society. There is also spending on pensions. Figure 2, below, shows public spending rising to 11.3 per cent of GDP for health and social care combined, plus the OBR's central projections for public expenditure on pensions and pension benefits. The two pie charts are sized to show the projected growth of the economy, again showing that there is more money in real terms to be spent on other things.

Figure 2 Long-term projected share of GDP for health, social care and pensions using OBR central projection for pensions and pensioner benefits plus impact of commission's recommendations



Source: King's Fund calculations based on OBR and PSSRU data

In addition to public expenditure there is private spending on social care. That is not easy to calculate, although as set out in our interim report, and with some important assumptions, we estimate it to be around £12.6 billion in England in 2011/12 or around 0.8 per cent of the GDP (*The King's Fund 2014a*, p 42).

Under full implementation of our recommendations, a considerable proportion of this would move across to public spending and be included in the above projections as much more social care became free at the point of use.

Were this change not to be made, we would underline that the financial burden on individuals and their families for private long-term care would grow quite dramatically both as an absolute number and as a proportion of GDP – even with the Care Act changes.

In other words, overall spending on the cost of care for older people will inevitably rise given the ageing of the population. The question is not *whether* this money is spent. It is about *where* the costs fall – on collective provision through public expenditure, or on those individuals and families who are unlucky enough to have very high care needs. Some of these may be affluent enough, but many will have only modest means.

By 2025 England's public spending on health and social care combined would barely match what comparable countries spent 15 years earlier

To return to the international context, these projections show that with much more generous provision of publicly funded social care than even we are recommending, public expenditure on health and social care combined might reach somewhere between 11 and 12 per cent of GDP by 2025. That compares to the 18 per cent of GDP that the United States spent on health alone in 2010. It also compares to 11.2 per cent spent by Canada, the 11.6 per cent spent by France or the 11.9 per cent spent by the Netherlands in 2010 on health alone. Each country also has additional public expenditure on social care. In other words, by 2025 public spending on health and social care in England would only broadly match the proportions of GDP that these countries spent on health alone 15 years earlier.

We therefore recommend that the government should plan on the assumption that public spending on health and social care will reach between 11 and 12 per cent of GDP by 2025 (Recommendation 7).

5 Paying for the new settlement

Summary

- Productivity improvements must make a contribution.
- We see little scope for new NHS charges, but more money could be raised by radically reshaping the existing prescription charge.
- Those past state pension age are much better off than preceding generations of pensioners and they will be among the biggest beneficiaries of the new settlement we seek.
- The subsequent older generation – those now aged 40 to 65 – will also benefit significantly because they will have to devote fewer resources (time, energy and money) to caring for their older relatives. As a matter of equity and inter-generational fairness, today's older generations will need to make significant contributions to the costs of the new settlement.
- These can be achieved through a revamped prescription charge; better targeting of winter fuel payments and free TV licences; rationalising the treatment of accommodation costs in health and social care; and by ending the exemption from employees' National Insurance contributions when people work on past state pension age. We also propose a 1p increase in the rate of National Insurance for those aged over 40 as a health and social care contribution.
- These measures would pay for the first parts of our new settlement in the shorter term. For full implementation, other tax changes would need to be considered, including, we suggest, new wealth taxes.

There will be some very hard choices if England is to increase its public spending on health and social care combined to over 11 per cent of GDP. Health and social care will have to compete against other spending programmes as the economy recovers. While economic growth will improve the public finances, there looks to be less scope for reducing other areas of public expenditure than in the past – for instance, when the end of the cold war produced a large 'peace dividend' in reduced defence expenditure and the privatisation of large parts of previously nationalised industries reduced public subsidies for them.

Our new settlement has to be paid for, and there are essentially three ways of doing that:

- using existing health and social care resources more efficiently
- raising more private funding
- raising more public funding, or divert existing public expenditure into health and social care.

We believe that a mix of all three is needed, although our recommendations are heavily weighted towards the last of these options. We now look at them in detail.

Using existing health and social care resources more efficiently

Rationing or 'limiting' the NHS

In our interim report we looked at the options for limiting access to certain NHS procedures or treatments, or for trying to create a formally defined NHS benefits package. We do not favour that idea on the grounds set out in our interim report (*The King's Fund 2014a*, pp 44–45). England already has a well-established and internationally respected method of deciding which treatments the NHS should and should not provide in the form of the National Institute for Health and Care Excellence. This provides a much more flexible approach to this issue in the areas of both health and social care than seeking to define a menu of NHS treatments.

Productivity

Seeking out productivity gains must be a permanent part of any health and social care system in order to allow existing resources to be better spent. There are well-documented widespread variations in both costs and clinical quality within the NHS, and the long-standing attempts to address them plainly need to continue. As The King's Fund has argued there are clearly gains to be made here that should be pursued (*Appleby et al 2014*). In social care there is growing evidence that demand can be reduced by taking measures to restore and promote independence, and by commissioning, procurement and workforce changes. It has been suggested, for example, that in several local authorities 60 per cent of people using re-ablement services do not need further ongoing care (*LGA 2014b*). It is also clear that councils can do much through investing in services such as education, leisure and housing to improve the health of their local population (*Buck and Gregory 2013*).

Furthermore, we believe that the better integration of health and social care that lies at the heart of our recommendations will over time lead to better use of resources and thus better value for money as well as a better experience for patients and their families.

End-of-life care

As our interim report noted, this is a contentious issue, raising questions about how officiously the health service should strive to keep people alive. We do not enter this debate, although we note the current parliamentary debates about assisted dying. What is clear is that many people express the wish to die at home when they in fact die in hospital, and that some relatives feel on occasion that there can be excessive intervention.

An independent review of palliative care commissioned by the government in 2010 recommended a series of pilots aimed at collecting the data needed to create a tariff for palliative care. The review's modelling suggested that optimised services in the community could reduce the number of deaths in hospital by 60,000 by 2021, reducing hospital costs by some £180 million (*Hughes-Hallett et al 2011*). Eleven pilots have been launched, and we await their outcome with interest. People with terminal illness would be particular beneficiaries of our proposal that those with critical levels of need should receive free personal care.

Raising more private funding

For reasons that we will not repeat here, our interim report explained that we were not minded to support tax relief on private medical insurance, or the introduction of a ‘patient passport’ ([The King’s Fund 2014a](#), pp 47–49). That essentially leaves the introduction of new NHS charges, or the extension of existing ones, as the only means of raising additional private funding for health.

1. The potential for new NHS charges

We have considered a range of these carefully, but we see little scope for introducing them.

The United Kingdom, including England, is notable for its low level of private spending on health care. Private spending in this context includes charges within a health care system, as well as expenditure on purely private health care.

OECD data show that in 2010 the United Kingdom spent 1.6 per cent of its GDP on private health care against an average for EU countries of 2.4 per cent – a difference that would translate into around £12 billion of additional expenditure if the UK figure were raised to 2.4 per cent. An OECD survey in 2010 of 29 of its 34 member states showed that all have some form of co-payment or charge for pharmaceuticals, as does England. England is somewhat unusual in two ways. First, the charge – £8.05 currently for a prescription item – is relatively high. Patients do pay significantly more in some countries, but in many the charge or co-payment is nearer the £5 or €5 mark. Second, and not coincidentally, England has very extensive exemptions. Some 40 per cent of the population are required to pay, but in practice less than 10 per cent of prescriptions are charged as those most likely to need medicines are in the very extensive exempt categories.

The NHS is also a relative outlier in having no other significant health charges other than for dentistry. The same OECD survey showed that only 9 of the 29 countries had no payment for visiting a GP, or the equivalent. Half of the 29 countries – 15 of them – have some charge or co-payment for hospital treatment. In England, the two main charges – for prescriptions and dentistry – raise about £1.1 billion between them, or less than 1 per cent of the health service budget. As a result, as the OECD has noted, patients in the United Kingdom enjoy ‘an especially high level of financial protection from the consequences of illness’ ([Smith and Goddard 2009](#)).

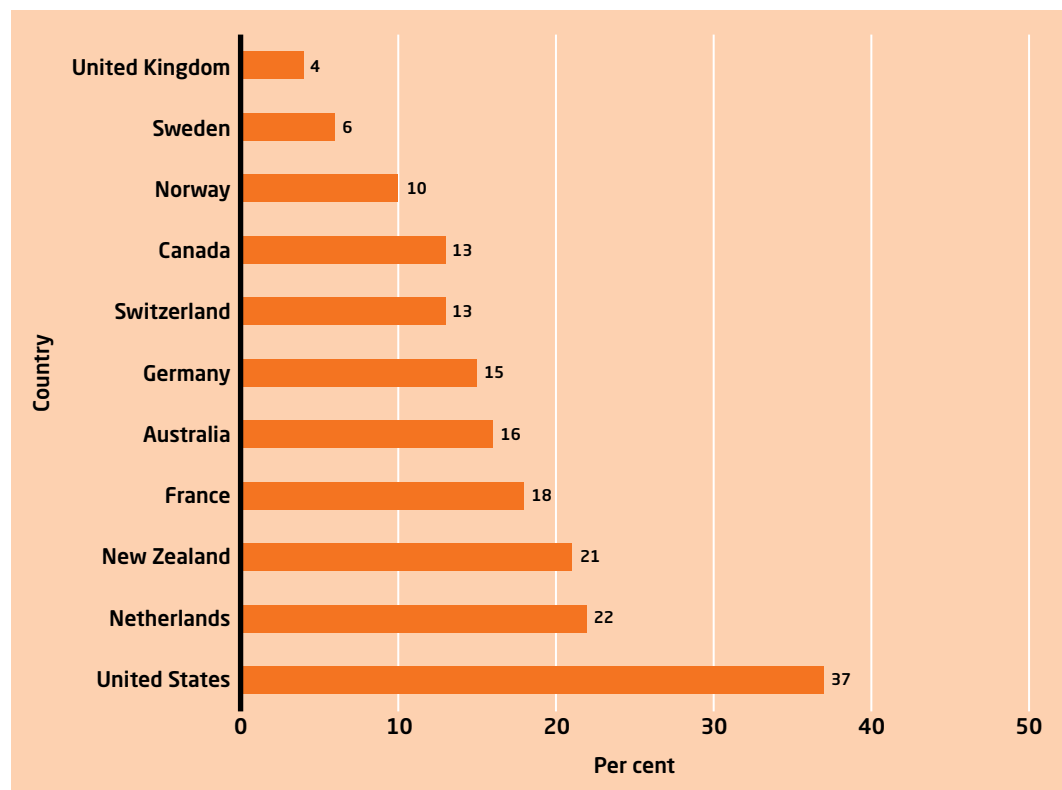
The impact of charging

The international evidence on the impact of charging – how far it controls unnecessary demand, or how far it leads to people foregoing necessary care – is in fact frustratingly weak. The only properly controlled study of various levels of user charges, ranging from zero upwards, was conducted by RAND in the United States in the 1960s. It produced results whose interpretation is still disputed by some ([Newhouse 1993](#); [Newhouse 2004](#)). Most academics, however, agree that it demonstrated that while health service usage fell as the level of charge rose, for most patients there was little or no detectable effect on the health outcomes that were measured, even at quite high levels of charge. There was, however, one notable and important exception – namely that charging above zero had a serious adverse effect on those who were both poor and suffering from poor health, the poor being defined in this study as those in the bottom 20 per cent of the income distribution. At a time when concern over inequality is rising, this is a major argument against charging everyone. It would fail the criterion of equity. Without being able to use such a clear-cut experimental design, researchers have found it hard to assess the impact

of user charges elsewhere. However, Peter Smith, Emeritus Professor of Health Policy at Imperial College, London, judges that the analyses that have been done in other countries ‘appear to corroborate the RAND results’ (Smith 2009).

It is also notable that in the Commonwealth Fund’s 2013 survey of 11 countries, patients in the United Kingdom were appreciably the least likely not to have filled a prescription, not to have visited the doctor with a medical problem, or not to have pursued their recommended care because of cost (Schoen *et al* 2013).

Figure 3 Experienced cost-related access problem* in the past year, Commonwealth Fund International Health Policy Survey in 11 countries (2013)



* Did not fill/skipped prescription, did not visit doctor with medical problem, and/or did not get recommended care.

Source: Schoen *et al* (2013)

The fact that charges are low by international standards might present a *prima facie* case that more could be raised from charging without a significant impact on necessary health care use, providing that there are exemptions for the least affluent. Even Scandinavian countries such as Sweden, which are typically seen as highly collectivist, have a charge for visiting the GP.

If the primary aim of a charge is to raise revenue rather than merely send a signal aimed at deterring use, then it needs to be pitched high enough to outweigh its administrative costs, and it needs to have relatively few exemptions. The higher the charge, however, the greater the burden it places not so much on the least affluent, who are likely to be exempt, but on those in low-paid work who earn just enough not to qualify for low-income exemptions. So those advocating new or extended charges need to be clear about their primary purpose – to raise revenue or deter usage – and their likely impact. How far, in other words, would they be prepared to see the United Kingdom’s position in Figure 3 deteriorate?

The commission has considered a number of possible new charges for NHS services.

- **A charge for visiting the GP.** This could be pitched low (at say £5 a visit) or high (at say £25 or even £50). There are some 300 million consultations in primary care a year, of which around two-thirds are with a doctor and one-third with a practice nurse or other health professional. A £5 charge with no exemptions might therefore raise around £1.5 billion, a £25 charge would raise some £7.5 billion – before administrative costs and before any deterrent effect from the charge.

There is unfortunately no good data on GP visits broken down by both age and income, so what follows involves some extremely broad-brush estimates. A low charge of £5, with significant exemptions along the lines of the current prescription charge (which would exempt some 60 per cent of the population), would raise very little. It could be as little as £150 million before administration costs, if the pattern of visits to GP surgeries reflects the pattern of prescription charging – in other words, only 10 per cent of visits would actually be charged. A higher charge of £25, levied with a similar approach, might raise something closer to £750 million before administration costs and any deterrent effect.

Exemptions could be made much less generous. In its interim report, the commission noted that the current generation of pensioners are so significantly better off on average than their predecessors that the case for treating all pensioners as poor no longer bears scrutiny. Around one in four pensioners are entitled to the means-tested pension credit or pension credit guarantee. If only those on such means-tested benefits among older people were exempt from a £5 charge, that might raise an additional £650 million – assuming that the usage of GPs by those on means-tested pension benefits is similar to the uptake of older people in general for prescriptions. So perhaps a £5 charge that exempted only those on low income, including only those on pension credit, might raise £800 million in total. A £25 charge on a similar basis might raise around £4 billion. However, a £25 charge would be particularly onerous for those in low-paid work with earnings just too high to qualify for exemption. A cap of some sort on the total charge in any year would be needed to prevent those who need frequent GP visits from facing very high bills. Depending on where that was pitched it would significantly reduce the income.

There are, however, other problems with charges for a primary care consultation. First, would the charge apply only to a visit to the GP, or would it apply also to a visit to a practice nurse or other primary care health professional? If only to the GP visit, would the other visits attract no charge, or a lower one, and how would that affect the behaviour of GPs and patients? Second, there is an important trend towards email and telephone consultations in general practice. Would these attract the same charge, or a lesser one? The same charge might discourage a shift to such consultations. A lesser one would reduce the income received, and there are problems in defining when an email consultation comes to an end – it can change subject on its way through. Furthermore, a charge to visit the GP could not realistically be introduced in England without one also being introduced for visiting accident and emergency (A&E) departments, on the grounds that a charge for one and not the other would be likely to divert even more patients to already overloaded A&E departments.

Alongside the undoubted pressure there would be for extensive exemptions, these are serious practical difficulties. There are, moreover, strong arguments, on the grounds of both public health and equity, that England should continue to run a health care system that people enter before there is any thought of charging them. The commission does not want to see an approach where charges might deter people with communicable diseases from seeking medical help – for example, TB and HIV

and other sexually transmitted diseases. There are also concerns that charges could encourage people to put off seeking medical help more generally, leading to higher costs later as conditions that could be treated early become worse. It would penalise those with long-term conditions who use primary care regularly as our experts by experience have reminded us. The commission is thus not in favour of introducing a charge for GP visits.

- On similar grounds, the commission is also **opposed to a charge for outpatient attendance and for A&E**. There are many fewer such visits than GP appointments so charges would raise much less money – a few hundred millions of pounds at most for a £10 charge, before exemptions, administrative costs and deterrent effects. Charges and exemptions would be particularly hard to apply in the sometimes barely controlled chaos of an A&E department at weekends, and the sums eventually raised would be trivial in a £100 billion budget.
- **Charging patients who do not attend**. This idea is regularly trailed as a way of deterring patients who miss GP and hospital appointments, thereby wasting NHS resources. It has a superficial appeal. However, it would incur similar administrative costs to introducing charges more generally for a GP visit or hospital attendance while bringing in significantly smaller sums. Some sort of appeal mechanism for patients who miss appointments for good reasons would almost certainly be needed, adding to the administrative burden. There would be the additional cost of pursuing those who did not attend. Some vulnerable patients who need medical care could be deterred from returning if they faced a charge for missing an appointment.
- **A ‘hotel’ charge for hospital stays**. On any given day there are approximately 120,000 NHS beds occupied overnight in England, and some 10,000 beds are in use for day cases (NHS England 2014a). A £10 ‘hotel’ charge per overnight stay, without any exemptions, could thus raise around £1.2 million a day or around £450 million a year. A £50 charge would raise some £2.25 billion, and a £100-a-day charge approximately £4.5 billion. (The accommodation cap for residential care introduced by the Care Act will be around £33 per day.)

Such a charge would go some way to aligning the health and social care systems more closely in that people would be responsible for their accommodation costs until their income is low enough to receive means-tested support. The average length of stay in hospital in England has been falling – down from 7.9 days to 5.2 days over the past decade. So the ‘average’ bill from a £10 overnight charge would be around £50, or around £250 for a £50 charge, and so on. There would, however, be significant variations around that average.

Fierce debate is likely over who should benefit from exemptions from such an NHS ‘hotel’ charge. The longer the stay, the higher the charge, and the more it would be seen as ‘a tax on the sick’, although clearly some sort of cap could be applied. Exemptions, even if they went only to those on low incomes, would significantly reduce the revenue raised. Most families already face additional costs of travel when they have a relative in hospital. A substantial administrative system would be needed to bill people and exempt them. The net gain from such a charge would be relatively small unless it was pitched at the higher end of possible charging levels.

- **A charge per procedure or treatment**. An administratively much simpler and cheaper approach would be to have a flat-rate charge per admission or procedure. This could be presented as a contribution to treatment, but would doubtless also be criticised as a health ‘poll tax’. There are myriad ways in which such a charge might be levied, but one would be to have a flat-rate charge per ‘finished consultant episode’, a definition that broadly translates in laymen’s terms into a course of

hospital treatment. In 2012/13 there were just under 18 million finished consultant episodes in England, so a £10 charge, with no exemptions, would raise about £180 million before administrative costs. To raise a significant sum of money, any charge would need to be appreciably higher than that. A £50 flat-rate charge would raise around £900 million with no exemptions, and a £100 charge some £1.8 billion. Those sums, however, would rapidly fall even if exemptions were extended only to those on low income or pension credit and to children, and some sort of cap to the charge would be needed for those who face repeated admissions.

The commission does not believe there is much to be gained financially by introducing new charges for NHS care. More importantly such charges risk adverse impacts on health, particularly for those with incomes just above the level at which any exemptions were set. It would also erode one of the significant principles underlying the creation of the NHS: that health care should be freely available to all who need it, regardless of income.

2. Potential changes to existing charges

The vast bulk of the income that the NHS currently receives from charges comes from two main sources – dentistry and prescriptions.

NHS dentistry

NHS dentistry in England cost £2.9 billion in 2012/13, of which 22 per cent, or £650 million, was recouped in charges. Exemptions are somewhat complex, but broadly speaking NHS dentistry is free to children under 18, pregnant women and mothers whose child is under 12 months, and people on a variety of means-tested benefits. It is not free for older people unless they are on pension credit ([NHS Choices 2014](#)). NHS treatment is paid for through a three-band charging structure, depending on the complexity of treatment, with the top band currently costing £219, and with charges covering approximately 80 per cent of the cost of treatment. Given that the exemptions are already tightly drawn, the commission sees little room for raising money from higher charges or tighter exemptions.

Prescription charges

Some 1 billion prescriptions are dispensed annually in England, with £450 million raised from prescription charges in 2012/13 when the charge was £7.65 an item. (It is currently £8.05.) Some 40 per cent of the population are liable to pay prescription charges. But not only are exemptions from the charge extensive,¹ but they also cover those groups – people aged over 60, children, and some with specified medical conditions – who are the heaviest users of prescription medicines. As a result, while 40 per cent of the population are liable to pay the charge, in practice 90.6 per cent of prescriptions are dispensed free.

Of the 9.4 per cent of prescriptions that are paid for, slightly more than half – 5.2 per cent – are, so to speak, cash payments, the remaining 4.2 per cent being covered by pre-payment certificates, which effectively provide a cap on the maximum people need to pay. These cost £29.10 for three months and £104 for a year. They are a considerable bargain. Anyone knowing they will need four or more prescriptions in three months, or

¹ Current main prescription charge exemptions are: being 60 or over, under 16, between 16 and 18 and in full-time education, being pregnant or having had a baby in the previous 12 months, having a specified medical condition, having a continuing physical disability that prevents you going out without assistance, having a valid war pension exemption certificate, being an NHS inpatient. In addition, those on Income Support, income-based Jobseeker's Allowance, income-related Employment and Support Allowance, Pension Credit Guarantee or Universal Credit are exempt.

Table 3 Percentage of items that were charged for or dispensed free, 2012 exemption category

	%
Charged at point of dispensing	5.2
Pre-payment certificate	4.2
Total charged	9.4
Proportions dispensed free	
Older people	58.9
Young	5.3
Maternity	0.7
Medical	7.4
NHS low-income scheme	11.5
No-charge contraceptives	0.8
Other	6.1
Total free	90.6
Total number of items dispensed (millions)	1,000.5

Source: Health and Social Care Information Centre (2013)

more than 14 prescriptions in a year, saves – and the savings can be significant. Someone regularly on three prescriptions a month saves £185 over a year. They are, however, *pre-payment* certificates, so people have to be aware in advance that they are likely to need medication. As our experts by experience pointed out to us, for someone who has an income just too high to qualify for low-income exemption, finding £100 upfront can be a financial challenge.

However, the current charging regime makes little sense. Exemptions apply from the age of 60, when the state pension age will shortly be 65 for both men and women. The existing medical exemptions are widely acknowledged to be ‘inconsistent and arbitrary,’ although to be fair that charge is usually made by those who want to extend medical exemptions (Gilmore 2009). As our interim report noted, it has long since ceased to be the case that all pensioners are poor (Johnson 2013; The King’s Fund 2014a, pp 28–29, 58–59). There was some limited support among our experts by experience for more affluent older people to pay prescription charges, and for the age exemption to rise to that for state pension age. That is a view the commission shares.

Prescription charges may not be a popular part of the NHS, but they are a long-established one. However, for someone who pays for their prescriptions and needs two or three medications at a time, the £8.05 charge per item is a significant sum.

We believe there is a way to reform these charges that would, at the same time, raise some additional money.

With 1 billion prescription items being dispensed in 2012/13 and some £450 million being raised, the prescription charge could be lowered to 45p with the same sum raised provided there were no exemptions and no cap on payments. Each additional £1 charge would therefore raise an additional £1 billion.

On that basis, a £2.50 charge – a near 70 per cent reduction in the existing charge, and less than the price of a pint of beer or about that for a posh coffee – would raise around £2 billion a year. That sum would be reduced if the pre-payment certificates, or some other form of cap, were left in place – and the commission does favour the retention of a cap so that those on lower incomes do not face excessive costs.

Under this approach, medical exemptions and the low-income scheme would be abolished for all, including pensioners, but no one would face a medicines bill of more than £104 a year on the current cap. With the advent of electronic prescribing, it must be possible to devise an approach where the number of items dispensed are added up as they go along, with patients ceasing to pay once they hit the cap. That would remove the requirement to fund a pre-payment certificate upfront.

Below the age of 60, pre-payment certificates cover only a little more than 4 per cent of prescriptions. But that percentage would be much higher among older people once their blanket exemption from prescription charges was removed as they make heavier use of prescription drugs. There are a number of parameters that can be adjusted here, including the level of the charge, the extent of the exemptions and the generosity of the cap. Nonetheless we estimate that a change along these lines would raise several hundreds of millions of pounds, and possibly around £1 billion, without imposing an undue burden. **We recommend that the government launch a review of prescription charges on these lines with a view to raising approximately an additional £1 billion a year (Recommendation 6).**

Raising more public finance

There are, of course, myriad ways that more public finance could be raised. So we have sought to focus on ones that best meet the criteria of fairness set out in our interim report.

1. Hypothecation for health and social care

Since our interim report, we have examined in more detail the case for a hypothecated tax for health and social care, not least because others are airing the idea, particularly in relation to NHS funding.²

Arguments in favour of hypothecation are that it links the electorate to the purposes of taxation. It provides some sense of what the service costs and what people are paying for it. It may encourage people to support a tax rise for a particular service – though it may do the opposite if people sense that too much is being spent.

Finance ministries across the world, including HM Treasury, tend to be highly resistant to the idea, chiefly on the grounds that hypothecated taxes reduce flexibility in deciding on spending priorities that will change over time. The argument goes that spending decisions should be based on priorities, not on the way the money is raised. Once a significant tax is earmarked there may well be pressure for hypothecation in other areas and indeed pressure from some to opt out of the tax. ‘I want a hypothecated health, defence, education, environmental tax that I can opt out of because I do not use the service, or I don’t believe in the service.’ Earmarking may also put pressure on spending for less ‘popular’ services – for example, welfare benefits or defence.³

An additional problem is that the take from earmarked taxes is likely to rise and fall with the economic cycle in ways that bear no relation to the ‘need’ or ‘demand’ for the service. Indeed in the case of health, and possibly also social care, demands on the health service may well rise in times of recession (as unemployment produces an increase in anxiety and depression), just when revenues are falling. It makes no sense to spend more on health and social care in boom times just because revenues are higher. So some sort

² See, for example, Finkelstein (2014); Pearce (2014); Wilby (2014); Harrop (2014); Field (2014).

³ For a useful brief history and discussion of hypothecated taxes see House of Commons Library Note, SN01480, September 2011. For a case in favour see Le Grand (2003), chapter 11.

of balancing fund or mechanism to smooth out the good and bad times is likely to be needed. That may not be an insuperable objection, but it weakens the direct link between the money raised and the money spent.

It should be noted that hypothecation need not necessarily lead to higher taxes for a particular service – it could be purely presentational. It is worth making distinctions between political, partial and full hypothecation, and what might be dubbed ‘soft’ and ‘hard’ hypothecation.

Both Conservative and Labour chancellors have in the past nominally linked a rise in tobacco tax to NHS spending – a form of soft hypothecation. The most dramatic example of soft hypothecation in recent years was Gordon Brown’s decision in 2002 to put an additional 1 percentage point on National Insurance to pay for a large increase in NHS funding. But there is no Treasury account of how much the increase has raised and of how it was injected into NHS funding over the years, relative to what would otherwise have taken place. In other words, the increase was in part a political and presentational manoeuvre, even though it did of course raise additional taxation that allowed a rise in NHS expenditure.

That 2002 National Insurance increase is also an example of partial hypothecation. Even in 2004, when the National Insurance contribution was highest, almost 80 per cent of the NHS budget still came from general taxation and charges. In theory, such hypothecation could be made ‘harder’ by putting it into a specific ring-fenced fund and clearly accounting for the amount it raised and for the way it was spent.

Here, however, an additional problem arises, one that also applies to any new charge for the NHS. In year one, or perhaps in the first couple of years of a spending round, it is possible to demonstrate that the ‘new’ or ‘extra’ earmarked taxation has indeed led to an increase in expenditure. Thereafter, however, with partial hypothecation, no one has any idea of how much the government would have spent on the NHS from other sources. The earmarked fund in practice merely becomes part of the overall NHS settlement which is reached by political decisions within the government of the day. In other words, partial hypothecation remains a soft form of the idea, and one that may rapidly become a lie.

A further alternative is full hypothecation – where an earmarked tax funds the whole cost of the NHS, or in our case the whole of public expenditure on health and social care (given that we want a single, ring-fenced budget for both health and social care).

The commission has not been alone in noting that the £110 billion income from National Insurance, along with tobacco, wine and spirit duties (which might be dubbed ‘health’ taxes), very broadly matches current public expenditure on health and social care combined. Superficially, they appear to offer ready-made components for a health and social care tax.

It is important to note, however, that even though the link is much weaker than it used to be, National Insurance contributions do still produce entitlements to a number of non-means-tested benefits, including the basic state pension. Some way of preserving such entitlements would be needed. It is important to note also that using National Insurance rather than general taxation in this way – even with some adjustment to extend National Insurance to those past state pension age – would overwhelmingly switch the burden of paying for the additional costs of health and social care on to the working population. The older generation, who are consuming very roughly half of health and social care expenditure, would pay remarkably little towards the improved entitlements. In contrast, under general taxation, they do in fact contribute appreciable sums through the payment of income tax, VAT and other taxes.

An alternative might be to create a new health and social care tax that did apply to income across all generations, with off-setting reductions in other forms of taxation, although there would be significant difficulties in designing both that and the transition.

The need for a stabilisation fund to deal with excess money in the good times and too little in the bad would remain. Arguably a mechanism might be required to decide how much ‘needs’ to be spent in any given year on health and social care.

One way of doing that would be to hand over the budget and the tax-raising powers to an independent body, for example, a new Office of Health and Social Care. It would be charged with assessing demand or need within the overall entitlements set by the government of the day, making a judgement on what efficiencies health and social care might reasonably be expected to achieve in any given year, and setting the budget, with the power to vary tax rates to keep the fund in balance.

A weaker version would see an independent body make those assessments, offering transparent advice to the government of the day. That advice would cover spending levels, the balance of the tax against that, and any adjustments needed in the tax rate. The government would then accept or modify its recommendations.

The commission can see the attractions of hypothecation. It is not convinced, however, that a move to full hypothecation is feasible at this point.

It does, nonetheless, see merit in the idea of an independent official body making regular assessments of the health and social care needs of the country, and of the spending needed to meet those. Given the changing evidence base as the population ages, that would provide an evolving picture of what is required to provide a fit-for-purpose health and social care service.

The Wanless report of 2002 offered this, helping to justify the big increase in health spending that followed. Wanless himself recommended that the exercise be repeated at regular intervals. **We do the same (Recommendation 12).**

2. A direction of travel for funding reform

Our proposals for a new settlement for health and social care involve significant extra spending over the years to get England to a health and care system fit for the 21st century. That cannot be achieved overnight. It will have to be phased.

A first step – making what is currently defined as critical care free at the point of use – would cost appreciably less than £3 billion if introduced today. But on top of that, increases in spending on the NHS will be needed in both the short and longer term.

Given the resources and time available to us – and given that our new settlement does not precisely mirror current entitlements – we have not attempted to model the full costs of what we propose. Instead we set out a number of measures that between them would raise and release an additional £5 billion for health and social care funding to set a direction of travel for funding reform. It should be noted that the government has already committed to finding £2.64 billion by 2025 to implement the Care Act changes.

Our starting point on how to fund reform is similar to that of the Dilnot commission. As we have noted, those close to the state pension age, and those recently retired, are much more affluent than previous generations of retirees. Pensioner poverty is at its lowest for decades, according to the Office for National Statistics (2013). Work by the Institute for Fiscal Studies shows that mid-point pensioner incomes are now similar to

those of the working-age population, and more than 40 per cent of pensioners are in the top half of the income distribution. That still leaves a wide variation in pensioner income, with some 2.4 million people claiming pension credit in England.

The overall picture, however, at least for the immediately foreseeable future, is of a generation of younger older people – those more recently past state pension age – who are not just better off in terms of income than the generation before them, but significantly so. They also have much greater wealth. The younger ones among them have benefited from the maturing of the second state pension and from the final salary pension schemes that are no longer available to younger workers, and from what are in effect significant ‘windfall’ gains from rising property prices.

There is an issue of inter-generational fairness, although we do not wish to overstate it. Only around half of both NHS and social care expenditure goes on those aged 65 and over, and their children and families also gain in myriad ways, emotional as well as financial, when their parents receive high-quality care and support.

It is also important to note that the next generation of older people (those aged 40 to 65) will also benefit considerably from our proposals. They will be much better supported – in terms of their time and energy, as well as money – in caring for their older relatives.

Given this position we recommend on the grounds of equity, affordability and inter-generational fairness that at least **some of the extra revenue to pay for the large-scale improvements that we seek should come from the group that will be among the biggest beneficiaries of the changes, namely the older generation and particularly its more affluent members (Recommendation 8).**

That can be achieved in a number of ways.

- i. First, resources can be released by targeting existing benefits more precisely, away from affluent pensioners, and diverting the money into health and social care. Like many others, we believe that free TV licences for the over-75s and winter fuel payments should no longer be provided on a universal basis. **We recommend that they should be limited to those on pension credit, a move that the Institute for Fiscal Studies calculates will raise some £1.4 billion (Recommendation 8).**
- ii. Second, the reform of prescription charges that we outline above should raise another £1 billion or so from NHS charges. **We recommend that the government undertake a review of prescription charges that would involve dramatically lowering the charge to perhaps £2.50 while significantly reducing the exemptions, with a view to raising at least £1 billion (Recommendation 8).**
- iii. Third, those past state pension age no longer pay employee National Insurance contributions when they continue to work. This exemption provides an incentive to carry on working, which we do not want to see entirely removed. **We nevertheless recommend that the existing exemption from employee’s National Insurance once people reach state pension age should cease, but that it should be paid at 6 per cent rather than the standard 12 per cent. Initially that would raise around £475 million (Hansard (House of Commons Debates) (2013–14)) (Recommendation 8).**
- iv. Fourth, our sixth recommendation, that accommodation costs should become means-tested for what is currently defined as Continuing Healthcare, would release some resource to help make critical care free at the point of need. It is difficult to calculate precisely how much, but we believe it would be in the region of £200 million.

These measures combined would raise revenue or release resources from the older generation in the order of £3 billion to be spent on supporting and improving health and social care.

They apply only to income, however, and wealth is much more unevenly distributed than income, across the older generation as well as at other ages. The commission believes further work must be undertaken on more effective means to tax assets, including the assets of the older generation.

Inheritance tax is one obvious possibility. It currently raises just less than £3 billion a year although that will increase to nearer £4 billion by 2017/18 as the government has frozen the threshold at which it is paid to help fund the Care Act changes. This will also help to fund our alternative approach. It is, however, plagued by avoidance, with the wealthiest able to indulge in tax planning to the point that it has been described as almost a voluntary tax for those at the upper end of the income distribution. It is resented for many reasons. One key reason is that once an estate becomes liable to the tax, it is paid at 40 per cent. A thorough review of how the tax operates might produce a more graduated set of thresholds and rates under which it might be possible to raise more money while reducing, for all but the wealthiest, the incentive to avoid it entirely. We note that the Mirrlees review, a comprehensive study of the tax system undertaken under the auspices of the Institute for Fiscal Studies, observed that ‘it seems likely that an initial lower rate would command greater public acceptance’ (Mirrlees *et al* 2011).

The Mirrlees review proposed, as an alternative to inheritance tax, a tax on lifetime receipts from wealth transfers in place of inheritance tax. While it noted that there would be practical difficulties in implementation, it said ‘the case for a tax on lifetime receipts looks strong’ on grounds of ‘fairness and economic efficiency’ (Mirrlees *et al* 2011).

The case has also been made for revisions to property taxation, for ending the forgiveness of capital gains tax at death, and for introducing that tax for primary residences. All of these, over time, could raise revenue that could be devoted to health and social care.

Capital gains tax is not charged on a household’s main dwelling, but is charged on second homes and on rented properties. The exemption was brought into some disrepute when the scandal about MPs’ expenses revealed the scope for ‘flipping’ the designation of the main dwelling. Tightening up the capital gains regime in this respect would seem uncontroversial.

Charging capital gains tax on gains on our main residences would bring the taxation of housing more into line with that for other assets. But there are complications. If it is charged on every transaction a household makes, then there is a real disincentive to move. However, if the tax is rolled up on a sequence of housing transactions over a lifetime each taxpayer would need to have a record of their capital gains tax liability which would be payable at the time of ‘last sale’ in the housing market (often on death). In addition, the charge might need to be reduced to take account only of house price rises above inflation. Even so, the case for applying capital gains tax to housing is powerful though it would face strong public and therefore political opposition.

In 2010, the Labour government proposed a comprehensive scheme for funding free personal care. It estimated it that would require a £20,000 contribution per person at age 65, payable at the time, in instalments or at death. Others have suggested a ‘charge and cap’ approach to raising money from estates for health and social care. This would involve a flat-rate charge – which might again be £20,000 – but with a cap on the percentage of any given estate taken by the charge. Modelling by the Strategic Society Centre suggests such an approach could raise several billion pounds (Lloyd 2011). Further variations put to us in evidence include levying a percentage charge on wealth at the point of state pension age. Again options could include paying it as a lump sum, in instalments, or at death. Shifting the time of payment to death could, however, produce similar problems of tax avoidance to those that affect inheritance tax.

A criticism often levelled at proposals to fund more social care from the public purse is that this effectively protects inheritances. Our proposals will indeed protect to some extent those whose inheritances could otherwise have been very substantially reduced by their parents having to meet the cost of social care. However, the burden of financing our proposed settlement for social care will be very largely borne by the better-off, but spread more fairly across this group. So many will inherit a little less, rather than a substantial minority inheriting a lot less.

It was not part of the commission's remit to design new wealth and asset taxes, but **we recommend that the government undertake a comprehensive review of wealth and property taxation with a view to spending all or part of the proceeds on health and social care (Recommendation 11).**

Our recommendations even initially will be of benefit not just to older people but to those currently in their 40s and 50s – both when they need care and support themselves and as they see their parents' generation gain from this new settlement.

We therefore recommend that as the more generous parts of our new settlement are phased in, a 1 percentage point increase in employee National Insurance is introduced for those aged over 40 as a health and care contribution (Recommendation 9). We do not have a precise figure for how much that would raise. But a 1 percentage point increase on the main rate across the board increases government revenue by around £3.5 billion in 2014/15, according to HMRC (2014). We make no recommendation on the timing of this change, but it might bring in revenue in the order of £2 billion a year.

Finally, we recommend an additional contribution from the income of the most affluent. At present those above the current upper earnings limit for National Insurance – just under £42,000 a year – cease paying employee National Insurance at the standard rate of 12 per cent. Instead they pay only 2 per cent on earnings above that threshold. **We recommend a further 1 percentage point increase to 3 per cent which would raise an additional £800 million a year, according to HMRC (HMRC 2014) (Recommendation 10).**

Taken together, these measures would raise or release more than £5 billion for health and social care, the timing of their introduction depending on the phasing of our recommendations.

Beyond that, a wide range of measures are possible. As the Institute for Fiscal Studies has noted, employer contributions to pensions are not subject to National Insurance contributions and are the only major form of employee remuneration that escapes them. It has argued that 'it is hard to justify the extraordinary generous NICs treatment of employer pension contributions'. Assuming that employer contributions continued at the same level, applying National Insurance to them would raise an estimated £10.8 billion a year. Such a levy, however, might see employers reduce their contributions, producing both a significant impact on pension saving and a lower tax take. Scrapping the tax-free pension lump sum that allows individuals to take 25 per cent of their pot tax-free would bring in another £2.5 billion a year, on the Institute for Fiscal Studies calculations. Equally tax relief on pension contributions is currently granted an individual's marginal rate so that the more affluent who pay income tax at the higher rates of 40 and 45 per cent receive a much larger subsidy for their pension saving than those who pay basic rate. Restricting tax relief to the basic rate would potentially raise £9.5 billion a year, according to the Institute for Fiscal Studies.

We make no recommendations in this area. But we do observe that there are myriad ways in which tax revenue can be increased, other than by raising the basic rate of income by 1p (which raises approaching £4 billion a year), or by increasing VAT by 1 percentage point

(which raises a little more than £5 billion), or by raising the main rate of National Insurance by 1 percentage point (raising some £3.5 billion a year) (HMRC 2014).

We do not pretend any of these choices are easy. Raising more money from prescription charges, means testing winter fuel payments and free TV licences, extending National Insurance to those who work on past state pension age, and the range of other tax increases that we recommend or say should be considered are all hard choices. But the stark truth is that without them England's health and social care system will progressively decline to a state that no civilised country should accept, and without them it will not be possible to build the new settlement we believe is necessary.

6 Recommendations and conclusion

Recommendations

Recommendation 1

A new settlement is needed for health and social care in England that breaks down the historic divide between the two systems and provides a much simpler path through the current maze of health and social care (p 6).

Recommendation 2

England needs to move to a single, ring-fenced budget for health and social care, with a single commissioner (p 6).

Recommendation 3

A much simpler path through the whole system of health and social care should be designed to reflect changing levels of need, with Attendance Allowance brought within the new single budget. The new approach should be based as far as possible around personal budgets in order to give service users a more powerful voice in reshaping which services are provided where and in what way, and as the commissioners themselves use the power of the single budget to integrate services (p 6).

Recommendation 4

There should be more equal support for equal need. In the long run that means making much more social care free at the point of use. Given the need to get the public finances back on a sustainable sound footing, we recommend that:

- First, those whose needs are currently defined as ‘critical’ should receive free social care, ending the current distinction between free NHS Continuing Healthcare and means-tested social care at the highest level of need.
- Second, that as the economy improves, free social care should be extended to those with ‘substantial’ needs.
- Third, that some support should be extended to people with moderate needs by 2025, with the expectation that they would be expected to contribute to those costs subject to a means test (p 15).

Recommendation 5

We recommend that work be undertaken to explore whether and/or how the health and wellbeing boards could evolve into the single commissioner for our new settlement.

Recommendation 6

We do not recommend any changes to NHS charges, with two exceptions:

- The treatment of accommodation or ‘hotel’ costs outside hospital should be rationalised. New recipients of NHS Continuing Healthcare should be required to meet their accommodation costs on the same means-tested basis as those who currently receive critical care, up to the £12,000 a year annual cap laid out in the Care Act 2014 (p 7).
- A radical recasting of the prescription charge. We recommend a dramatic reduction of the existing charge of £8.05 an item to perhaps £2.50, with many fewer exemptions, but the total payment an individual would face in any one year would be capped. The precise design of such a change requires further work that the Department of Health should undertake with a view to raising at least £1 billion (p 31).

Recommendation 7

The government should plan on the assumption that public spending on health and social care will reach between 11 per cent and 12 per cent of GDP by 2025. This will involve some significant tax increases. But as the economy grows, health and social care will be able to take a larger share of the much larger cake that economic growth produces (p 22).

Recommendation 8

The older generation, and those approaching state pension age, will be among the biggest beneficiaries of our new settlement, and we recommend, on the grounds of inter-generational fairness and equity, that they should make a significant contribution to the additional costs involved in our recommendations (p 34). We recommend:

- Free TV licences for the over-75s and winter fuel payments should be restricted to the least affluent pensioners, with the money saved diverted to spending on health and social care (p 34).
- The existing exemption from 12 per cent employees’ National Insurance for those who work past state pension age should end. Rather than pay the full rate, however, work incentives should be maintained by a levy of 6 per cent (p 34).

Recommendation 9

Our recommendations for much more social care to be free at the point of use will have to be phased in. As that happens we recommend an additional 1 percentage point employees’ National Insurance contribution for those aged over 40 as a contribution towards the more generous settlement from which they and their parents will benefit (p 36).

Recommendation 10

We recommend an increase to 3 per cent in the additional rate of National Insurance for those above the upper earnings limit, again timed to match the extensions of free social care (p 36).

Recommendation 11

With a view to raising additional revenue, we recommend a comprehensive review of wealth taxation to include possible reforms to inheritance tax, a wealth transfer tax, changes to capital gains and property taxation (p 36).

Recommendation 12

Given the changing evidence base as the population ages and medical advances continue, we recommend that the government adopt the recommendation of the Wanless review of 2002 and institute a regular review of the health and social care needs of the country and the spending required to meet them (p 33).

Conclusion

As this set of recommendations makes clear, England faces some hard choices if it wants a health and social care system fit for the 21st century. Increasing the income from prescription charges, means testing some universal benefits and raising significant additional taxation will not be popular.

However, such measures, or similar ones, are needed: first to prevent a steady erosion of the existing public provision of health and social care, and then to move to the new settlement we set out.

While our new settlement does recommend higher taxation, the prize it offers is huge. It would provide more equal support at the highest level of need, regardless of whether that need is currently defined as health or social care. The path through the health and social care system would be simplified. At the lower levels of support individuals and families would have more control over the services they receive, and at the highest levels much more of what is currently defined as social care would be free at the point of use.

The existence of a single, ring-fenced budget, singly commissioned, should bring some immediate advantages and, in the longer term, the potential for some very significant ones through integrated services delivering better value for money. There would be one budget and one commissioner for individuals and their families to deal with, in place of the health and social care systems and the Department for Work and Pensions.

Change on this scale cannot possibly be introduced overnight. Indeed, given the state of the public finances, getting to our fully implemented vision is likely to be a journey of a decade.

On the entitlement side, we have recommended that the first priority should be to make what is currently defined as critical care free at the point of use. This would end the current distinction between NHS Continuing Healthcare and social care at the highest levels of need.

That would still leave needs that are currently defined as substantial being means tested, though operating after 2016 within the new funding arrangements introduced by the Care Act 2014. As the economy improves, the next priority would be to make substantial needs free at the point of use. In time we would like to see some support for more moderate needs. In the meantime, some resource to improve support at lower levels of need may be released by bringing Attendance Allowance within the health and social care system, and by providing more support to restore as much independence as possible to recipients of what we suggest should be renamed a care and support allowance.

We have not attempted to set out a precise time line for these changes as much will depend on the state of the economy. Nor have we set suggested dates for when the tax changes that we propose should take effect. These would need to move in line with the phasing in of our recommendations on entitlements. Indeed, were the next government to implement the current Chancellor of the Exchequer's declared intention to seek to merge income tax and National Insurance, our recommendations on National Insurance increases would need to be recast.

Because our terms of reference asked us to concentrate on the issues of funding and entitlement, we have not examined in detail the question of who the single commissioner should be. However, as we noted in our interim report, a sterile debate over whether local authorities take over the commissioning of the NHS, or the NHS take over the commissioning of social care, should be avoided.

Fortunately, the Health and Social Care Act 2012 has created health and wellbeing boards. These bring together local authorities, the commissioners of social care, and the clinical commissioning groups as the local commissioners of health services. They have legal duties to promote integration and to encourage the use of pooled budgets. They are fledgling organisations. They do not themselves commission but they are already charged with overseeing an integrated approach to commissioning and delivery across a whole range of services. These arrangements already provide blueprints for how a single local assessment could underpin an integrated single budget.

Various commentators and analysts, including the House of Commons Health Select Committee, have noted that over time health and wellbeing boards could evolve into the single commissioners of health and social care locally. That is an idea with attractions. But the boards would clearly need strengthening. We would emphasise that if they were to become the new single commissioner they should evolve into this role, rather than be switched to it on a single day. Initially, for example, it would be possible to continue allocating the single health and social care budget, including Attendance Allowance, to local authorities and clinical commissioning groups, with a reinforced duty on them to co-operate in commissioning. Over time they would be able to apply to become the single commissioner.

Our new settlement raises other issues that go well beyond our terms of reference. We would observe, for example, that to get the very real gains that our new settlement offers, much more data-sharing will be needed to get the most from the more seamless, integrated service that we seek. A start has been made in the integrated care pilots by insisting that the unique NHS number be used as a common identifier. Much more, however, needs to be done to overcome public suspicion of sharing data across health services and local authorities so that health and social care services can be improved in ways that are plainly to the advantage of both individuals and society.

The much more integrated service that we and others seek also has significant implications for the workforce, and for who employs them. More care in people's homes and in the community will require a re-think of the current divides between care and clinical staff and the roles that they play.

These are issues of much more than detail. They will be for others to address. But they are not irresolvable as England moves to the new settlement that we recommend – a much more integrated service, with a much simpler path through it, with more equal treatment for equal need, and with both individuals and the single commissioner better able to reshape services around an individual's needs, regardless of whether they involve health, or social care, or both.

Appendix A: The commission

Terms of reference

The terms of reference for the commission set by The King's Fund were to consider whether the current differences in the entitlements, benefits and funding of health and social care are fit for the 21st century.

- Does the boundary between health and social care need to be redrawn? If so, where and how? What other ways of defining these needs could be more relevant/useful?
- Should the entitlements and criteria used to decide who can access care be aligned? If so, who should be entitled to what and on what grounds?
- Should health and social care funding be brought together? If so, at what level (ie, local or national) and in what ways? What is the balance between the individual and the state in funding services?

In reaching a view we were asked to consider:

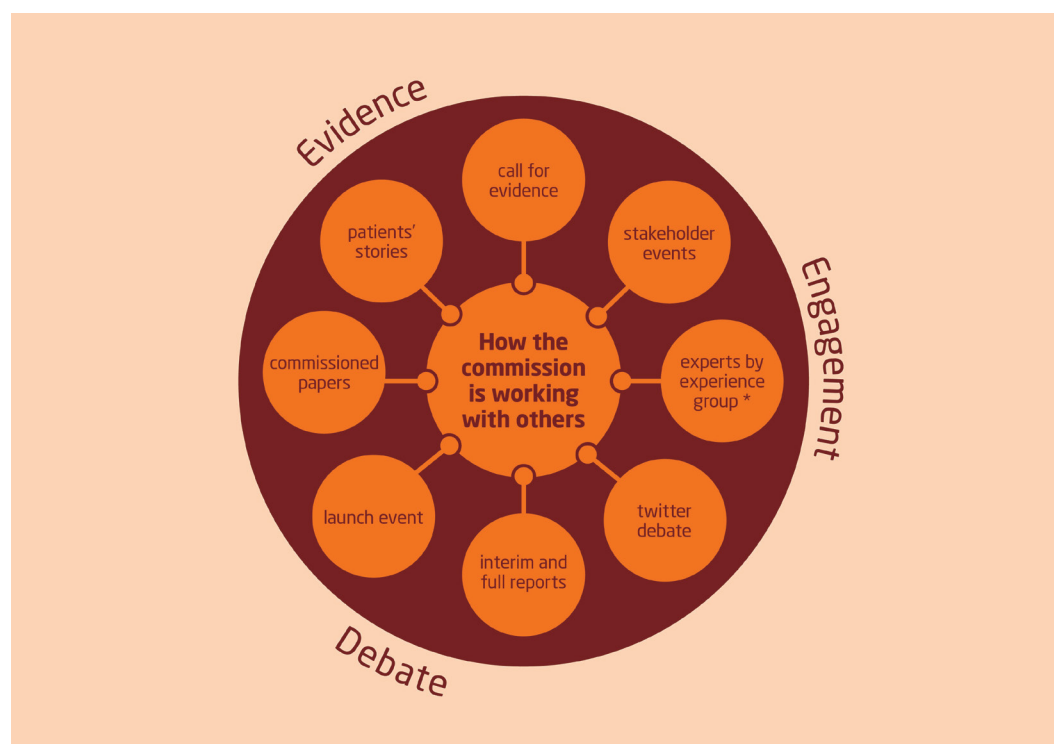
- changes in the needs of older people and those of working age with disabilities and long-term health conditions
- changes in the models of care to meet these needs and how they are delivered
- changes in public expectations and the values that underpin welfare entitlements
- changes in the disease burden and the social and medical response to these.

If we reached a view that changes were needed we were asked to consider:

- who gets what?
- who pays how much?
- how would the state contribution be funded?
- to what extent would an individual be expected to fund their contribution, and how?
- what effects would this have on equity of access and outcomes?

In addressing these terms of reference, we have sought to draw ideas, evidence and information from a wide range of sources to help our thinking about what is wrong with the current separate systems of health and social care and to consider options for change.

Figure A1, opposite, sets out our overall approach to engagement and evidence.

Figure A1 The commission's approach to engagement and evidence

* This includes patients, carers and people who use care and support services.

The work of the commission

In addition to the work as set out in the interim report:

- We issued a second **call for evidence** to seek the views on the following series of questions:
 - Do you agree with our conclusion that a new settlement in health and social care is needed?
 - If so, do you support our proposition for a **single ring-fenced budget** for health and social care that is **single commissioned**, and within which **entitlements** to health and social care are more **closely aligned**?
 - Should the aim be to achieve more **equal support for equal need**, regardless of whether that support is currently considered as health or social care?
 - If so, should social care be more closely aligned with health care (that is, making more social care free at the point of use)? Or should health be aligned more closely with social care (that is, reducing the extent to which health care is free at the point of use)?
 - Do you think that adequate funding for health and social care requires:
 - increased charges in the NHS? If so, for what?
 - increased charges for social care? If so, for what?
 - cuts to funds from other areas of public spending, re-allocating it to health and social care? If so, from what?
 - an increase in taxation? If so, which taxes would you favour increasing?
 - none of the above? If you answer yes to this, is it because you think that funding for the health and social care system is adequate, and that extra demands can be met by using existing resources more efficiently? Or is it for some other reason? Are there other views or evidence that you think we should consider?

Responses were received from 64 individuals and organisations. A summary of these responses can be found online at www.kingsfund.org.uk/publications/new-settlement-health-and-social-care

- We held **three stakeholder engagement events** in London attended by a total of 28 people from a range of national and local organisations involved in the planning, delivery and regulation of services. Participants in these events were invited to focus on the questions set out in the call for evidence.
- We met with **key leaders in the health and social care arena** to explore funding options and choices.
- We met with **the advisory group of experts by experience** in May. A summary of the experts by experience group's contribution can be found online at www.kingsfund.org.uk/publications/new-settlement-health-and-social-care
- We held **16 formal meetings** overall, as well as attending the stakeholder engagement events and other meetings.
- We made available a **variety of material about our work** on the Barker Commission website: www.kingsfund.org.uk/projects/commission-future-health-and-social-care-england

Our criteria

The criteria we used to assess our proposals for change are:

- Are they equitable according to reasonable interpretations of quality?
- Do they deliver the highest quality of service from the available resources, including efficiency?
- Are they affordable now and likely to remain so under future demands for health and social care?
- Are they consistent with notions of individual and collective responsibility?
- Are they designed around, and responsive to, the needs and preferences of users and carers?
- Are they transparent and capable of being clearly interpreted?

Appendix B: Health and social care spending projections: methods and assumptions

For NHS spending the commission has taken an annual real growth figure of 3.5 per cent, for reasons explained in the main text (*see p 20*). This increases real spending on the NHS from around £109 billion in 2013/14 to around £165 billion in 2025/26 (at 2013/14 prices), increasing its share of GDP⁴ from 8 per cent to 9.1 per cent over this period (*see Table B1, below*).

The projections for social care spending are a combination of improving access to free care with moderate eligibility requirements for that portion of the social care budget spent on older people (around 42 per cent of the current spend) and then projecting forward to 2025/6. These use the dynamic micro-simulation model developed by PSSRU at the London School of Economics and the University of Kent. These projections are based on ONS 2012 population projections for older people, assuming a 1.5 per cent real terms increase in unit costs. The remaining portion of spend (58 per cent) is projected to 2025/6 on the basis of the OBR's 'high initial health and social care spending' variant (*OBR 2014*). On this basis, spending increases from £24 billion in 2013/14 to £40 billion in 2025/6.

Overall, the projections to 2025/6 represent a real-terms increase of £72 billion (an average annual increase of around £4.25 billion, equivalent to annual real increases of 3.7 per cent). This would increase the share of public spending on health and social care from 9.7 per cent of England's GDP to 11.3 per cent (based on OBR GDP central projections for UK GDP, scaled to England based on population).

⁴ An English figure for GDP has been calculated on the basis of the UK figure adjusted on the basis of England's share of the UK population.

Economic growth and the implications for additional taxation/changes in public spending priorities

The table below also shows the OBR's central projection for GDP growth (again, this has been scaled to England based on population shares).

Table B1 OBR central projection for GDP growth

Scenario		2013/14		2025/26		Change 2012/13 to 2025/26	
		Per cent of GDP	£bn (2013/14 prices)	Per cent of GDP	£bn (2013/14 prices)	Per cent of GDP	£bn (2013/14 prices)
Commission recommendations							
NHS	3.5% pa real growth	8.0%	109	9.1%	165	1.1%	56
Social care	Free care, moderate eligibility	1.7%	24	2.2%	40	0.4%	16
Total		9.7%	133	11.3%	204	1.5%	72
OBR fiscal sustainability report projections, 2014							
NHS	Higher initial health and social care spending	8.0%	109	8.3%	151	0.3%	42
Social care		1.2%	17	1.5%	28	0.3%	11
Total		9.2%	126	9.8%	179	0.6%	53
GDP	<i>England share of UK GDP</i>		1,365		1,816		451

On this central projection, the economy grows from around £1,365 billion in 2013/14 to £1,816 billion in 2025/6 – an increase of £451 billion in real terms (a growth of over a third). This growth has implications for the proportion of the recommended additional spend (£72 billion) that would need to be found from additional taxes and/or reprioritisation of public spending overall).

If tax revenues grow in line with general economic growth, then around 40 per cent of the recommended additional health and social care spend could be funded from this increase (around £29 billion). This would leave around £43 billion by 2025/6 to be funded from other sources – such as a combination of increased taxation and reduced shares of government spending on other areas of public spending. It should be noted that this does not necessarily mean reductions in real terms in other areas, but reduced shares of total government spending (which will have grown in real terms reflecting growth in the economy as a whole). While the commission's projections imply an increase in the share of government spending on health and social care from around 22 per cent in 2013/14 to 27 per cent in 2025/6, on the assumption of constant government spending as a proportion of GDP overall (around 41 per cent), this increase would allow for a 24 per cent real increase in non-health and social care spending.

John Appleby
Chief Economist
The King's Fund

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