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DEREK WANLESS

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wanless
social
care
review

Securing Good Care for Older People

TAKING A LONG-TERM VIEW

Summary

How much will it cost to provide social care for older people in England in 20 years time? What funding arrangements should be in place to ensure this money is available and supports the high-quality outcomes sought? Particularly now that the ‘baby-boomer’ generation is moving towards retirement, these questions pose serious challenges. Finding sustainable solutions will depend on understanding the demographic, economic, social and health trends driving demand over the coming decades.

At the heart of the issue should be a debate about what social care will do in the future. How will it help people? What outcomes should it aim to achieve? Who should it help? Once its purpose is understood and specified, important decisions can then be made about the range and type of services, the size and composition of the workforce, the implications for housing, the use of technology to assist people to live with more control, and the extent of preventive action required to avoid or delay need.

More than one million older people (aged 65 and over) currently use publicly funded social care services in England. Local authorities spent £8 billion on personal social care services in 2004/5, £1.6 billion of which was recouped from users through means-tested charges. A further £3.7 billion was paid out to individuals on (non-means-tested) benefits to help towards the costs of care. And private spending on residential and home care by older people is likely to be more than £3.5 billion a year.

Yet, despite these considerable sums, there is little information about whether this spending achieves the government’s desired aims for older people of promoting choice, independence and prevention. Some trends suggest that these aims are not being achieved. For example, older people prefer to receive care in their own homes, yet local authority spending on care home placements has risen at a faster rate than that on home care. In 2004/5, almost 60 per cent of local authority gross spending on older people’s social care went on residential and nursing home placements. Furthermore, in directing resources to people with the most intensive needs, a substantial number of people with lesser but still significant needs are not being helped in many cases.

There is also widespread dissatisfaction with the current funding system. In part this results from ignorance about what to expect. It often comes as an unwelcome surprise to older people to discover that social care is means-tested and they are expected to rely on their own savings and income until their assets have fallen to the threshold set for state-funded care. It is a common complaint that the existing system penalises those who have saved for their old age.

Overall, public spending on social care has historically been constrained or limited by the budget available. Budgets have generally been based on historical allocations and have

been subject to competing local demands. This has not allowed for any long-term assessment of funding requirements, despite the pressures of an ageing population and an increase in chronic health conditions.

Against this backdrop, the King's Fund commissioned this year-long Review, led by Sir Derek Wanless, whose previous reports for the Treasury covered future health care spending in the United Kingdom and public health in England. This Review seeks to determine how much should be spent on social care for older people in England over the next 20 years. It also considers what funding arrangements need to be in place to ensure this money is available and supports high-quality outcomes. It is hoped that the results will make a significant contribution to the debate on the future of social care.

The terms of reference for the Wanless Social Care Review are:

- to examine the demographic, economic, social, health, and other relevant trends over the next 20 years that are likely to affect the demand for and nature of social care for older people (aged 65 and over) in England (Part 1)
- in the light of this, to identify the financial and other resources required to ensure that older people who need social care are able to secure comprehensive, high-quality care that reflects the preferences of individuals receiving care (Part 2)
- to consider how such social care might be funded, bearing in mind the King's Fund's commitment to social justice (Part 3).

The Review team has examined social and health care policy, services and spending as well as demographic, social and technological trends. The analysis was used in the development of a model for estimating the level of need over the next 20 years. The model was used to calculate how much it would cost to fund social care under three successively more ambitious scenarios of social care outcomes. This incorporated a method for establishing 'benchmark' packages of social care services to produce the most cost-effective outcomes. Finally, the Review assessed a number of possible funding mechanisms for providing the additional sums required.

The main body of the Review is divided into three parts: Evidence and Trends, Resource Requirements and Funding Options. The final chapter concludes by setting out the overarching themes and main messages that emerge, as well as a set of recommendations.

PART 1. EVIDENCE AND TRENDS

Part 1 assesses the state of social care today. It examines how well social care helps older people with disabilities, impairment and other needs. It looks at the quality of care provided and the current cost and funding arrangements, including how much people using services have to pay. The implications for the workforce, the substantial contribution of informal care, and an assessment of emerging new models for providing care are also considered.

Social care today and the policy context

Current debates about the provision and funding of social care must be viewed against the policy shifts of the past five decades. Chapter 1 reviews the move towards supporting older people to remain in their own homes for as long as possible, rather than viewing care

homes as an inevitable destination for the very old. It looks at the revolution taking place over the past 15 years that has seen local authorities scale back in-house provision in favour of independent providers. And it highlights the emerging emphasis on prevention and rehabilitation, which aims to reduce demand for high intensity services.

The needs of an ageing population

The population of England is ageing. In the next 20 years, the number of people aged 85 and over in England is set to increase by two-thirds, compared with a 10 per cent growth in the overall population. Between 1981 and 2001, increases in healthy life expectancy did not keep pace with improvements in total life expectancy. In future, the total number of people with disabilities, and potentially in need of care, will be higher. ‘How much more care will be needed?’ is the key question addressed in Chapter 2. In particular, disability in later life arises as a result of heart disease and stroke, sensory problems (vision and hearing), arthritis, incontinence, dementia and depression, so trends in these diseases and conditions can be used to estimate future numbers of people with social care needs.

In 2002, around 900,000 older people were considered to have high levels of need, according to the standard assessment of being unable to carry out one or more of the main activities of daily living (ADLs) (being able to wash, dress, feed, toilet, walk and so on). A further 1.4 million older people had low levels of need. Over the 20 years to 2025, the Review projects a rise in the number of older people who do not require care of 44 per cent, a 53 per cent increase in those with some need and a 54 per cent increase in those with a high level of need. Based on expert analysis commissioned for the Review, these increases reflect a future where population health improves due to moderate reductions in obesity and other ‘lifestyle’ conditions, as well as the introduction of effective new treatments or technologies.

Overall, the number of people with impairment and dependency will increase significantly over the next 20 years. This will increase the demand for social care, putting pressure on available resources and funding.

Shortcomings of the social care system

Chapters 3–5 consider how well the present social care system is performing for older people, and finds areas of significant shortfall in what it achieves. Some of this is the result of poorly delivered services, but it is also caused by limited funding and other resources.

Expectations are changing, and the so-called baby-boomers (born 1945–54) are likely to present a cohort of more demanding social care users in the future, strongly objecting to age discrimination and insisting on greater choice and quality. Most older people prefer to receive care at or close to home, and there is evidence that greater emphasis on respite care, day care and social work would improve outcomes. For people with low levels of need, there is some evidence that social care, often provided in the community, can delay the use of more intensive services such as nursing home care (Chapter 3). However, the recent trend in service provision is a move away from relatively ‘low-level’ services towards more intensive ones. This is illustrated by the decline in the number of people who receive home care but an increase in the number of hours of care provided in total.

There is evidence of significant unmet need. The proportion of all people in their own homes who have care needs and who have those needs met is low, and has been falling. Budget-limited public resources are successfully being aimed at those with the highest levels of need but, even among this group, services are only being used by a relatively small proportion of people with apparently similar levels of need. The Review also finds that unmet need is particularly high among moderately dependent people. Overall, the proportion of older people receiving home care in England is low by international standards.

Good management, organisation and standards in the care system should lead to better performance. Chapter 4 considers how well the current system fares in this regard. The Review found that councils with good assessments for adult social care services tended to spend more than those with poorer records. While compliance with minimum standards for care homes and home care services is improving, there is significant regional variation.

There is a growing body of evidence relating to the gains from better joint working between the health and social care systems. The government has promoted a series of measures to improve partnership working, but their use is far from widespread. There has been progress in reducing delayed transfers from hospital, but this has not been matched by reductions in avoidable admissions to hospital. In addition, distinguishing needs at the boundary of health care (free at the point of delivery, including NHS continuing care) and social care (means-tested) creates considerable anger and distress among older people and their families. The interface has become a flashpoint for arguments about inequities in the system.

Overall, there is potential to shift more care out of hospital and into the community, including social care, but simply re-directing resources without making arrangements to coordinate and integrate those services will be the least effective strategy.

The best way to measure social care performance is to examine the outcomes achieved, but this is difficult to do. Chapter 5 illustrates how a number of tools can make outcome measurement a practical reality, leading to improved targeting of resources. The Review finds that improved outcomes would result from supplying more hours of home care to a larger number of people.

Who pays what for social care?

How much does society currently spend on social care for older people? Chapter 6 looks at the main funding streams for social care and the means-testing system, which determines the charges imposed on users. Estimating total expenditure on social care for older people is complicated by the many funding sources. In 2004/5, local authorities spent £8 billion on personal social care services, and recouped £1.6 billion of this through means-tested charges to users; in addition, approximately £3 billion was spent by the NHS on long-term care of older people. Two social security benefits also provide funds that can be spent on social care; Attendance Allowance and Disability Living Allowance (care component), are the main sources of non-means-tested funding for older people with disabilities and in 2004/5 paid out £3.7 billion. There is no reliable data for the total amount of private spending on care home fees and self-funded domiciliary care, but the sums spent are substantial. Estimates put the proportion of care home places that are wholly privately funded at between one-quarter and one-third.

There is widespread dissatisfaction with the current means-tested funding arrangements. Criticisms include: the complexity of the system and associated lack of understanding of how it works; that savers and people with even modest assets are penalised, having to (at least initially) cover most of their care costs without state support; and the ‘post code’ lottery for domiciliary care charges, which results in large, and seemingly inequitable, differences in the level of charges imposed by different councils for similar care packages. Implementation of means-testing can create some perverse incentives so that financial rules affect the type of services people receive.

A significant proportion of people aged 50 and over are unlikely to be able to afford to pay privately for social care in retirement. Survey data demonstrates that disability is correlated with lower income and assets, so that those who are most likely to need long-term care are also least likely to be able to pay for it.

Who will do the caring?

Social care services are labour intensive so the availability and quality of staff are key factors in achieving the desired outcomes. An estimated 559,000 people in 2003/4 were formally employed in England providing ‘core’ social care for older people, not including around 120,000 NHS staff doing some care work (Chapter 7). Staff costs represent a significant proportion of care costs; for example, care assistant wages average just over half the unit costs of local authority commissioned home care services. In care homes, labour costs are estimated to account for just over half the weekly ‘fair price’ for residential homes, and two-thirds for nursing homes. Since 2002, pay rates for social care jobs have risen faster than inflation but vacancy rates remain high.

The care of older people relies heavily on informal carers. There were around 5.8 million carers in England in 2000, between 3.4 million and 4 million of whom were providing care to people aged 65 and over (Chapter 8). Older people themselves supply a disproportionate amount of informal care; in 2000, one in six people over the age of 65 were providing some form of care. Carer support and information services do exist, but are currently received by only a minority of carers. The availability of informal care may not keep pace with increases in care needs in the future, but informal care will remain vital in supporting older people. Greater carer support is needed to relieve some of the pressures.

New services and technology

Chapter 9 reviews the likely impact and cost-effectiveness of the main new service models. Often it is clear that these improve the quality of life of older people, but it can be harder to judge the overall impact on costs. Telecare brings health and social care directly to an older person, usually in their own homes, supported by information and communication technology. It has the potential to postpone and divert older people from moving into residential care and possibly hospital, and many pilot studies have shown positive results. But there has been no consensus over assessing costs, so it is difficult to model the future cost impact of the national implementation of telecare. Nevertheless, there is enough evidence now to bring telecare services into the mainstream.

The demands of an ageing society come too low on the list of strategic housing priorities, with the housing concerns of first-time buyers and key workers appearing more immediate. Extra care housing provides self-contained homes with round-the-clock care and support,

and offers the potential for independent living for some older people who can no longer manage in their own homes.

New models of dementia care will also be important given the projected increase in older people aged 85 and over. The use of dementia-specific care services, including telecare and dedicated housing, together with specialist care workers appears promising.

There is evidence that a range of preventative measures can reduce dependency, disability and ill health, and that such schemes should be targeted at those whose condition is likely to deteriorate or who have a high predicted risk of costly future needs. The potential of intermediate care to rehabilitate also appears to be more effective when focused on specific conditions or groups of people.

PART 2. RESOURCE REQUIREMENTS

Modelling the future

Fundamental questions need to be asked when estimating the future resource requirements of social care for older people. What is social care? What is it trying to achieve? And for whom? The aims of social care fall into two broad groups: first, ensuring that people are able to live in safety and to satisfy personal care needs, including feeding, washing, dressing and going to the toilet; second, enhancing well-being and social inclusion, so that older people are able to engage socially, and maintain their self-esteem. The larger the number of people for whom these goals are attained, the higher the overall outcomes.

Public funds are currently targeted on the most dependent. If local authorities had more money, then more people could be helped and those currently receiving help could be supported more intensively. Generally speaking, as would be expected, higher expenditure achieves a greater improvement in outcomes, such as more frail, older people being able to live as they would wish, carrying out activities of daily living, and being less limited by their disabilities. The task of this Review is identifying the appropriate level of resources needed for social care in the future. Spending more on social care means less money for other public services or less money left in people's pockets. Where should the balance lie? The Review addresses this question by asking how much society and individuals are willing to pay for certain improvements in outcomes.

Chapter 10 outlines a number of scenarios for the future, reflecting different levels of ambition and achievement of outcomes.

- Scenario 1 (**current service model**) is the baseline case. It assumes that the patterns of social care services and outcomes in the future will be the same as now, that is, the system is no more ambitious. The driver of higher future costs will be changes in the numbers of people with care needs.
- Scenario 2 (**core business**) goes further, changing what the care system does, and what it provides, so that it achieves the highest levels of personal care and safety outcomes justifiable given their cost.
- Scenario 3 (**well-being**) uses scenario 2 as a starting point, but also provides improved social inclusion outcomes and a broader sense of well-being.

For each of these scenarios, the Review's model combines projections of future need with the services required to achieve the desired outcomes. A number of key building blocks are needed to make such an estimate.

- The first is to assess the impact of services on outcomes. As part of its methodology, the Review uses a generic outcome measure – the ADLAY. This is the gain for one year of life of having core activities of daily living (ADL) needs improved from being entirely unmet to being fully met. It has strong analogies with the quality-adjusted life year (QALY) used in health care research. Mirroring methods used by the National Institute for Health and Clinical Excellence (NICE) in assessing health care interventions, the model set a maximum cost of £20,000 per year for achieving each unit of outcome gain. Any increase in costs will divert resources from other productive uses, and so needs to be balanced against the outcome gain. For scenarios 2 and 3 this balance is struck when social care services are provided up to the point where they cost no more than £20,000 for further ADLAY outcome gain. This analysis defines the economically-justified 'benchmark' levels of services.
- The second main component of the modelling work is a calculation of the level of informal care and its contribution to meeting overall demand for care. The outcomes of carers are considered, including the extent to which caring might adversely affect their health and stress levels. The cost-effectiveness of carer support services is assessed as part of improving outcomes for carers and hence the sustainability of caring.
- Cognitive impairment (including dementia) causes ADL problems but also generates other risks, such as to the person's safety. Addressing these risks improves outcomes, but also increases short-term costs. An understanding of what services are required to address cognitive impairment is the third building block.
- Fourth is an estimate of the impact of charges on the demand for social care services. To what extent do charges discourage older people from seeking care or reduce the amount they use? This factor is important, because if people are put off, then total costs are lower, but so are total outcomes. In scenario 2, older people are offered benchmark levels of care. Some, according to current charging rules, would have to pay a charge and may therefore decide to do without adequate care.

Cost projections

Using the Review's population and dependency projections, the model produces the following estimates of the cost of social care (using the central assumptions). At this stage no assumption is made about changing the current funding system, and these represent total costs, including public and private expenditure.

- Under scenario 1, total costs are projected at £10.1 billion in 2002, rising by 139 per cent between 2002 and 2026 to £24.0 billion. This is an increase from 1.1 per cent to 1.5 per cent of GDP. Scenario 1's total costs are the actual expenditures on social care for older people by Social Services and by individuals (but, for comparison with the other scenarios, removes the modest NHS funding of long-term care).
- Under scenario 2, total costs would have been £12.2 billion in 2002 had this scenario been in place, and costs are estimated to rise by 142 per cent between 2002 and 2026 to £29.5 billion, an increase from 1.3 per cent to 2.0 per cent of GDP.

- Under scenario 3, total costs would have been £13.0 billion in 2002 and are estimated to rise by 142 per cent between 2002 and 2026 to £31.3 billion, an increase from 1.4 per cent to 2.0 per cent of GDP.

The Review also considers the more immediate impact on spending of the three scenarios. In 2007, the difference between scenarios 1 and 2 in 2007 reaches £2.5 billion. In practice, scenario 2 will include some additional non-modelled costs that would push up this difference to £3 billion. This therefore is the estimated extra cost in 2007 of moving to a level of social care that achieves economically justifiable levels of personal care and safety.

Assessment and case management are vital components in the commissioning of services. They too have a cost, which is included in the above projections. In scenario 2 this runs to over £1 billion, which means that care-only expenditure would have been £11.1 billion in 2002.

All these projections rely on assumptions about unit costs, use of new technology, availability of unpaid care, dependency and the value-for-money threshold (£20,000 per ADLAY). The assumptions about cost inflation are particularly important.

Implications

On the Review's assumptions, the potential to achieve economically justifiable outcomes is not currently being realised. Unless society is less inclined to support the same improvement in outcomes from social care as it would from, say, health care, then more should be spent on social care for older people.

However, additional funding should not be forthcoming without a commitment to re-configure services, demonstrating value-for-money and fairness. This would include an increase in the size of community-based care packages for all those needing care, particularly the middle-dependency group; an improvement in carer support services; and the tailoring of care-with-housing services for those with significant cognitive impairment.

To achieve the outcomes in scenarios 2 and 3, the system needs to be made more universal with broader eligibility criteria.

This Review has made only tentative steps towards satisfying the well-being agenda, considering the impact of helping people with loneliness only. This is likely to represent just a small part of what could be done. Improved social participation, self-esteem through occupation and a sense of control over one's life are all well-being outcomes, but there is limited evidence on their cost-effectiveness.

There are several key drivers of higher cost. These include improved outcomes, demographic pressures and ensuring the robustness and quality of supply. Both scenarios 2 and 3 involve significantly more spending compared to the current situation. But it is important to emphasise that, even if this extra funding were made available in the near future, the required response on the supply-side would take a number of years. Spending would therefore have to be built up over a transitional period.

PART 3. FUNDING OPTIONS

The way social care is funded has changed little since the modern welfare state was established at the end of the Second World War. Local authorities operate a system of public funding that provides state-funded services to those with assets below a threshold level – although these are often subject to charges. The better off are expected to pay for their social care, including personal care, themselves. The value of a house is included in the means-testing asset assessment if the older person is moving into a care home (and no partner or qualifying person remains living there), but not for home care.

The means-testing system relates charges to ability to pay. For those receiving state support in care homes, the local authority will take all income (including pension and benefits) apart from a minimal weekly personal allowance. An older person receiving social care in their own home will usually be asked to pay charges so long as this does not reduce their net income below a certain level, which is linked with the pension credit system.

There are many alternative ways to fund social care, and different arrangements exist in other countries. Possible options include:

- providing some form of universal entitlement to social care that is state supported and not means-tested, for instance free personal care, as now applies in Scotland
- a social insurance model in which the state acts as an insurer and provides a package of care for people enrolled in the scheme, should they need care
- a partnership between state and individual where costs of care are shared for those needing care
- a limited liability model which caps an individual's liability for social care costs, either after a certain period or after they have made a specified financial outlay
- savings-based models, often with a link to pension provision, where the state contributes to an earmarked savings pot that the individual can use to pay for care.

There are also many possibilities for changing the current means-testing rules. For example, the assets threshold above which state-funded care is no longer available could be raised. Alternatively, the income level before charges are levied for home care could be increased, so that fewer people have to pay.

Various commercial financing products might assist those people who contribute privately to the costs of long-term social care. These include:

- long-term care insurance products, including their potential role in public–private partnership arrangements
- the use of housing equity release schemes to raise funds for meeting social care costs
- various financial incentives which could be offered through tax incentives.

There are a number of ways in which the broad funding options can be categorised: the degree to which funds come directly from people's own pockets rather than the public purse; the extent to which risks of costs are pooled between a range of people; whether an individual is entitled to a pre-determined amount of financial support for care or whether the amount depends on the size of the budget available, and so on.

Deciding how to pay for social care – and in particular how to meet the funding requirements set out in Part 2 – is the subject of Part 3. How are these choices of funding

system to be made? How are the relative merits to be judged? The Review applies a comprehensive set of tests or filters to narrow down the wide range of options. The tests – detailed in Chapter 11 – are grouped together under the headings: fairness, economic efficiency, user choice, physical resource development, clarity and sustainability/acceptability.

Chapter 12 investigates a broad range of funding and charging options and highlights the complexity inherent in funding long-term social care for older people. Although there is widespread disquiet about the current arrangements, no single prescriptive ‘answer’ exists that suits every older person’s financial circumstances and preferences. Funding solutions need to relate closely to the development of the model of services chosen, as well as changing expectations and aspirations.

Assessing the options

Applying the Review’s tests narrows down the options. Scoring best are a partnership model, free personal care, and a limited liability model. As a basis for comparison, the current means-tested system is also included, although it ranked below these others. In all these models, it is assumed that housing costs in care homes and at home are supported, as now, by a means-testing system.

The frontrunners differ in important ways.

- The **partnership** model provides people with a free-of-charge minimum guaranteed amount of care – this is set in the model at 66 per cent of the total benchmark care package, but could be varied either up or down. Individuals can then make contributions matched by the state (up to a limit): in the model, every pound that people contribute is matched by a pound from the state until the benchmark care package is achieved (thereafter extra private contributions are not matched). Those on low incomes would be supported in making additional contributions through the benefits system.
- **Free personal care** provides a full package of personal care without charge.
- A **limited liability** model is a hybrid, effectively a means-tested system for the first three or four years of care and then free personal care thereafter.

Costs and outcomes

In Part 2, the Review team estimated the total resource required for each of the three different scenarios, but the funding system (means-testing) was left unchanged. The focus was on total (public and private) costs of social care (including care management and assessment), and how this would change as better outcomes were achieved.

Changing the funding arrangements – moving away from the present means-testing system – obviously affects the costs borne by the state and the individual. Crucially, individuals can decide not to buy care or to buy less if they feel they cannot afford it or that they are being asked to pay too much. Thus, moving away from means-testing would change the amount of care consumed, and therefore both the outcomes achieved and the total (public and private) costs.

The results (Chapter 13) show the very different levels of public expenditure that would be required for scenario 2 under the four different funding options. (These are scenario 2 *care* costs for the base year (2002), up-rated for inflation to 2004/5.)

- Means-testing (under the current eligibility and means-testing guidelines) produces the lowest level of expenditure on formal care of £12.4 billion, and the lowest demand on state funds at £6.2 billion of spending on direct care. There would be 1.2 million older people receiving personal care, an increase of 12 per cent compared to the current situation. This total expenditure of £12.4 billion is the care-only costs from Part 2 for scenario 2 (£11.1 billion), but up-rated to 2004/5 prices.
- A limited liability option would increase public spending by approximately £1.2 billion to £7.4 billion. Limited liability arrangements do not bring about changes in the number of people that use services and therefore do not change total expenditure, or personal care outcomes.
- The partnership model brings about a significant increase in both total levels of spending and the contribution by the state to care costs. Relative to the means-testing system, direct public spending in this model increases from £6.2 billion to £9.7 billion, with a total spend of £13.7 billion. Uptake would be around 1.5 million people (an increase of around 45 per cent over the current number).
- Free personal care has the highest levels of spend (£14.9 billion) and the greatest funding contributions by the state (either £11.6 billion or £12.2 billion depending on the variant considered).

With free personal care, the state contributes approximately 78 per cent of total (direct) care costs, compared with just over 71 per cent in the partnership model, 60 per cent with limited liability and 50 per cent in the means-testing model.

The differences in costs are substantial. This is partly because scenario 2 provides larger care packages for individuals than the current system and therefore even a small change in the proportion of care supported by the state means a large cost difference. For example, among individuals with three or more ADL problems, the cost of the benchmark care packages is over 70 per cent higher than those offered today. Moreover, as both the partnership and free personal care models involve moving to universal entitlements, significantly more older people receive support compared with means-testing (over 300,000 more).

The state also currently funds care indirectly via the benefits system. The main benefits – Attendance Allowance and Disability Living Allowance (care component) – cost around £3.7 billion. These benefits are used to help pay charges under means-testing, to top-up care beyond that which is directly funded, and to cover non-care related costs. The data about their use is poor, but under means-testing, a large proportion is used to pay charges for care packages.

Under the partnership and free personal care models, direct state expenditure would cover the care-related uses of these benefits, reducing their justification. They could be significantly scaled back or even stopped under partnership or free personal care, especially if their non-care use was small and if claimants would also mostly be entitled to social care support. As a result, the difference in total public sector cost (direct and benefits) between mean-testing and partnership would be much reduced. In particular, if two-thirds of the total spent on AA and DLA (£2.5 billion) was transferred, this would leave the increase in public social care expenditure compared with current levels at £1.7 billion and £3.6 billion in the partnership and free personal care models respectively. The cost of supporting people on low incomes through the benefits system to help them afford care charges would be £0.8 billion or more.

Implications

There are value-for-money implications. Benchmark levels of services balance outcomes against costs. Free personal care funds services to levels higher than the benchmark, that is, more than society seems willing to support (given central assumptions). This implies that some public money might be better spent elsewhere. Means-testing funds services to levels below the benchmark where the converse is true: spending more on social care would be good value for money. But the partnership model can be fine-tuned so that expenditure is closest to the benchmark level. As a result, the partnership model achieves the best ratio of valued outcomes to total expenditure (117 per cent), followed closely by the free personal care arrangements (116 per cent) and finally by the means-testing-system (with a ratio of 113 per cent).

Free personal care would generate the most substantial call on public funding, which must be raised from elsewhere in the economy. There are political and economic costs of public funding (including the effects on the economy of higher taxes) that would need to be considered.

Both partnership and free personal care have better risk-sharing benefits than means-testing, because they provide services to more people. The anxieties individuals have about facing large care bills would be much reduced. Instead, they would have a clearer picture of their entitlement and how much they would have to pay.

There are also equity and fairness implications. The model shows the financial impact and the improvement in outcomes of the different funding arrangements on individuals with different levels of need and different wealth. Under each of the three funding options, the most dependent people get the most care. With different funding arrangements, people also get different levels of services depending on their wealth. Under the means-tested system, the eligibility rules lead to a stratification of people into three groups:

- individuals with low wealth, who qualify for state support and receive benchmark levels of care
- individuals with high means, who are able to secure high levels of services by funding their own care
- individuals between the two groups, a significant proportion of whom struggle to pay for their own care, and as a result do not receive enough formal support.

Free personal care and partnership models significantly help this middle group, by providing more care at lower charges.

The partnership model does levy charges but does not include means-testing in the care system. Instead, to help the poorest, the partnership model combines a needs-based care system with support for low-income people through the benefits system. People receive additional income benefits depending on the care charges they pay. But, although the low-wealth group would be better off under a partnership model than now (in terms of how much care they receive and how much is paid in charges), relatively speaking they would be *even* better off under a means-tested system in the future, albeit by a modest amount. This should be taken in context. As Chapter 13 shows, the vast majority of people would be much better off under the partnership model. For example, far fewer people would have to 'spend-down', that is, sell off assets such as their homes.

Free personal care and the partnership model both avoid penalising people who have made financial provision for their old age.

Means-testing fares poorly on choice, except for the most wealthy who always have choices. Free personal care puts the onus on social services in terms of what care is provided. Because there is a charge under partnership, people will feel more empowered to express choices.

The funding of social care is inherently complex. There are housing, domestic support, personal care and nursing care elements to many social care packages. Few people understand what they are entitled to and what they have to pay. None of the funding models escape this complexity. But in means-testing the rules for financial eligibility can be particularly difficult for older people to understand. Under free personal care and partnership models, no charge considerations apply for the guaranteed element. In partnership models, the rules for the amounts contributed by the individual and matched by the state are clear.

Where means-testing scores well is on financial sustainability, because many people either self-fund or are charged, and some of these are able to pay without difficulty.

Choosing a funding system

No single system for funding stands out in all respects above the rest. All have strengths and weaknesses. Choosing between funding options is therefore a process of comparing their relative strengths and weaknesses against the Review's tests.

On balance, the Review considers the partnership model the best option (Chapter 14). Assuming 2002 demand levels, the Review estimates that the additional public care expenditure required in scenario 2 ranges between £1.7 billion and £4.2 billion (at 2004/5 prices), depending on the extent to which dependency-related social security benefits (AA and DLA) would be scaled back and the money transferred into the partnership arrangement. In addition, the cost of supporting people on low incomes through the benefits system to help them afford care charges would be £0.8 billion or more. Scenario 2 is concerned with personal care and risk outcomes. Achieving broader well-being would involve further resources.

The particular strengths of the partnership model are as follows.

- It would limit means-testing to the benefits system, leaving care services to focus on meeting need.
- It provides a guaranteed minimum level of care, making the system universal and inclusive.
- It provides incentives for people to save for their needs in older age as almost everyone would be required to make some form of contribution.
- It produces best value-for-money – the best ratio of outcomes to costs.
- It forces far fewer people to dispose of assets to pay for care than under means-testing.
- It is sustainable – the system will cost more than means-testing but it also provides significant additional value by way of better outcomes in return; it also makes a charge that both deters use of service beyond the benchmark level and is an important source of revenue.

- It provides clarity about what care people can expect, how much they are entitled to receive, and also how much they have to pay.

But there are weaknesses with the partnership model.

- Compared with means-testing, the differential between what better-off people pay and poor people pay is lessened.
- Social care funding arrangements need to work with the benefits system. The partnership model is no exception, with all the complexities that this implies.
- The partnership model is not as expensive overall as free personal care, but it is more expensive than means-testing, at least in terms of the direct care costs. The political and economic costs of public funding (for example, the effects on the economy of higher taxes) need to be considered.

Ultimately, however, the choice of funding mechanism depends on value-based choices about the relative importance of containing public sector costs, maximising equal access to care, and balancing outcomes between high- and low-income groups.

Next steps

This Review seeks to contribute to a much-needed debate about how much social care is likely to be required in the future, and how to fund it. Social care for older people has been changing over the last five decades. This compounds the difficulties of specifying precisely what the purpose of social care should be in the future, what outcomes it should aim to achieve and where the boundaries should lie. With a paucity of good evidence and, too often, without adequate information about what social care does now, the task of assessing resource requirements in the future is a challenging one. And yet it is a crucial question, one that over the past 12 months has prompted a Green and then a White Paper from government. Many questions still remain about the detail and the costs; this Review has gone back to first principles to begin the process of finding answers. If its recommendations are taken forward by all those involved, a much clearer picture should emerge.

This Review has also drawn out the implications and consequences of different funding choices. It has highlighted the relative merits of the frontrunners and has identified the partnership model as, on balance, its preferred option; its implementation would represent a radical shift which would take time to organise and would need to take place alongside major shifts in the benefits system.

The Review has made a number of specific recommendations and these can be found in Chapter 14.