

## Summary: Intervention & Options

Department /Agency: <b>Department of Health</b>	Title: <b>Impact Assessment of Care and Support White Paper, Building the National Care Service</b>	
Stage: <b>Final proposal</b>	Version: <b>1.0</b>	Date: <b>30 March 2010</b>
Related Publications: <b>Building the National Care Service, Shaping the Future of Care Together</b>		

Available to view or download at:

<http://careandsupport.direct.gov.uk>

Contact for enquiries: **Becki Hemming**

Telephone: **020 7210 5288**

### What is the problem under consideration? Why is government intervention necessary?

Predicted demographic trends, the economic situation and changing expectations have created new challenges for the care and support system. Without reform, there is likely to be pressure on families to provide increasing levels of care and adults may go without the care and support they need. Government intervention through a state system sharing risk and costs across the population is needed to ensure people have access to care and support helping them stay independent and well for as long as possible.

### What are the policy objectives and the intended effects?

The Government commits to establishing a comprehensive National Care Service (NCS) for all adults in England with an eligible care need. Reform of the system is needed to deliver a more sustainable funding model for care and support in the future and deliver high quality care and support.

The National Care Service should treat people with dignity and respect and give them more choice and control over how they receive care and support, enabling individuals and their families to live the lives they want, supporting them to be independent and well.

### What policy options have been considered? Please justify any preferred option.

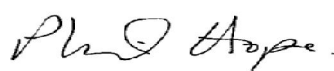
- 1) Do nothing
- 2) A Comprehensive care and support system
- 3) A staged approach to a Comprehensive care and support system

The preferred option is a staged approach to a Comprehensive system as being best suited to deliver the required policy objectives and intended effects in a fiscally-responsible way where the benefits justify the costs.

**When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects?** This is a long-term vision for reform. Further work will be required to assess policy impacts. Moving to Stage 3 of reform will be dependent on a further impact assessment once recommendations from the Commission are known.

### Ministerial Sign-off For final proposal Impact Assessments:

*I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.*



**Signed by the responsible Minister:**

**30 March 2010**

## Summary: Analysis & Evidence

Policy Option: Comprehensive	Description: A comprehensive National Care Service for all adults in England with an eligible care need, free when people need it
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COSTS	<b>ANNUAL COSTS</b>	Description and scale of <b>key monetised costs</b> by 'main affected groups' We consider illustrative net costs to the government of: i) providing additional care to more people; ii) cost of assessment and care management for more recipients of state care; iii) possible cost savings to NHS from increasing social care activity; and iv) costs of universal deferred payments for accommodation costs.
	One-off (Transition) <span style="float: right;">Yrs</span>	
	<b>£ Not fully mon.</b> <span style="float: right;">10</span>	
	<b>Average Annual Cost</b> (excluding one-off)	
<b>£ 4.4 bn 2016-25</b>		<b>Total Cost (PV) £ 28.9bn 2016-25</b>

Other **key non-monetised costs** by 'main affected groups' As described in the IA, some detailed measures are to be determined during the implementation period so their costs are not yet monetised, including some administrative costs of reform.

BENEFITS	<b>ANNUAL BENEFITS</b>	Description and scale of <b>key monetised benefits</b> by 'main affected groups' We consider illustrative net benefits to individuals and society from: i) reduction in private expenditure; ii) increased social care activity; iii) value of insurance; iv) distributional adjustment; and v) illustrative psychological benefits of deferred payments.
	One-off <span style="float: right;">Yrs</span>	
	<b>£ Not fully mon.</b> <span style="float: right;">10</span>	
	<b>Average Annual Benefit</b> (excluding one-off)	
<b>£ 5.5 bn 2016-25</b>		<b>Total Benefit (PV) £ 38.8bn 2016-25</b>

Other **key non-monetised benefits** by 'main affected groups' As above, some detailed measures are yet to be determined, so benefits not yet monetised. There may be additional benefits to carers from an improvement in the state offer. Incentives to save for retirement may be improved depending on recommendations from the Commission on ways to contribute to the NCS.

**Key Assumptions/Sensitivities/Risks** Key risks and assumptions made about the number of people with care needs, unit costs of care and the impact of reforms on demand in the future are outlined in Annex B and in the Fair Funding section of the Impact Assessment.

<b>Price Base</b> Year 2009	<b>Time Period</b> Years 10	<b>Net Benefit Range (NPV)</b> £ Not fully monetised	<b>NET BENEFIT (NPV Best estimate)</b> £ Not fully monetised
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<b>What is the geographic coverage of the policy/option?</b>		England			
<b>On what date will the policy be implemented?</b>		2016/17 (illustrative)			
<b>Which organisation(s) will enforce the policy?</b>		DH and LAs			
<b>What is the total annual cost of enforcement for these organisations?</b>		£ see Table 1			
<b>Does enforcement comply with Hampton principles?</b>		Yes			
<b>Will implementation go beyond minimum EU requirements?</b>		No			
<b>What is the value of the proposed offsetting measure per year?</b>		£ N/A			
<b>What is the value of changes in greenhouse gas emissions?</b>		£ N/A			
<b>Will the proposal have a significant impact on competition?</b>		See Annex A			
<b>Annual cost (£-£) per organisation</b> (excluding one-off)		Micro	Small	Medium	Large
<b>Are any of these organisations exempt?</b>		Annex A	Annex A	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices) (Increase - Decrease)

**Increase**    £ Not mon.    **Decrease**    £ Not mon.    **Net Impact**    £ Not monetised

Key:    Annual costs and benefits: Constant Prices    (Net) Present Value

## Summary: Analysis & Evidence

Policy Option: Free care for anyone in res. care for more than 2 yrs

Description: Free care for anyone in residential care for more than two years as an interim measure for a limited period until implementation of a comprehensive National Care Service

COSTS		ANNUAL COSTS	Description and scale of <b>key monetised costs</b> by 'main affected groups' We consider illustrative net costs to the government of: i) providing additional care to more people; and ii) cost of assessment and care management for more recipients of state care.
<b>One-off</b> (Transition)	Yrs		
£ Not fully mon.	2		
<b>Average Annual Cost</b> (excluding one-off)			
£ 0.8 bn 2014-15		<b>Total Cost (PV)</b>	£ 1.3bn 2014-15
Other <b>key non-monetised costs</b> by 'main affected groups' As described in the IA, some detailed measures are to be determined during the implementation period so costs not yet monetised, including some administrative costs of reform.			
BENEFITS		ANNUAL BENEFITS	Description and scale of <b>key monetised benefits</b> by 'main affected groups' We consider illustrative net benefits to individuals and society from: i) reduction in private expenditure; and ii) value of insurance.
<b>One-off</b>	Yrs		
£ Not fully mon.	2		
<b>Average Annual Benefit</b> (excluding one-off)			
£ 0.9 bn 2014-15		<b>Total Benefit (PV)</b>	£ 1.4 bn 2014-15
Other <b>key non-monetised benefits</b> by 'main affected groups' As described in the IA, some detailed measures are to be determined during the implementation period so benefits not yet monetised.			

**Key Assumptions/Sensitivities/Risks** Key risks and assumptions made about the number of people with care needs, unit costs of care and the impact of reforms on demand in the future are outlined in Annex B and in the Fair Funding section of the Impact Assessment.

Price Base Year 2009	Time Period Years 2	Net Benefit Range (NPV) £ Not fully monetised	NET BENEFIT (NPV Best estimate) £ Not fully monetised		
What is the geographic coverage of the policy/option?		England			
On what date will the policy be implemented?		2014/15			
Which organisation(s) will enforce the policy?		DH and LAs			
What is the total annual cost of enforcement for these organisations?		£ see Table 1			
Does enforcement comply with Hampton principles?		Yes			
Will implementation go beyond minimum EU requirements?		No			
What is the value of the proposed offsetting measure per year?		£ N/A			
What is the value of changes in greenhouse gas emissions?		£ N/A			
Will the proposal have a significant impact on competition?		Annex A			
Annual cost (£-£) per organisation (excluding one-off)		Micro	Small	Medium	Large
Are any of these organisations exempt?		Annex A	Annex A	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices)

(Increase - Decrease)

**Increase**    £ Not mon.    **Decrease**    £ Not mon.    **Net Impact**    £ Not monetised

Key:

Annual costs and benefits: Constant Prices

(Net) Present Value

## Evidence Base (for summary sheets)

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## Summary

'Care and support describes the activities, services and relationships that help people to be independent, active and healthy – as well as be able to participate in and contribute to society – throughout their lives.'<sup>1</sup>

This Impact Assessment provides an analysis of the costs and benefits of the reforms to the care and support system proposed in the White Paper *Building the National Care Service*. In the White Paper, the Government commits to establishing a comprehensive National Care Service for all adults in England with an eligible care need, free when they need it. The National Care Service is to be built in stages. An overview of the costs and benefits to build a National Care Service are outlined in Tables 1 and 2 below. As noted in the Impact Assessment, some of these costs are illustrative and others represent a central estimate. The Impact Assessment recognises that a number of costs for reform will need to be developed and refined as detailed implementation plans are made, following recommendations and working with the sector.

The White Paper *Building the National Care Service* describes the Government's intention to deliver the Personal Care at Home Bill, which provides free care at home for those with the highest needs. For the purposes of this Impact Assessment, the costs and benefits of the Bill are considered to be part of the status quo. This Impact Assessment therefore only considers an analysis of the additional costs and benefits of reform. This means that:

- the estimated costs of providing free care for anyone in residential care for more than two years are for this commitment alone and not for this commitment plus free personal care at home; and
- the estimated costs of a comprehensive National Care Service for all adults in England with an eligible care need, free when they need it implicitly encompasses free care for anyone in residential care for more than two years.

The first column of costs and benefits in Tables 1 and 2 (overleaf) consider the one-off costs of reform. These costs may take place over the period from 2011-2016 and should be seen as illustrative. Furthermore, there are further costs that have not been monetised at this stage (as they are dependent on recommendations and advice from the National Care Service Leadership Group and the Commission). Due to the remaining uncertainty and the illustrative nature of the costs monetised, we do not consider these one-off costs in the *Summary: Analysis and Evidence* cover sheets.

The costs and benefits over the period 2014/15–2015/16 consider implementation of free care for anyone in residential care for more than two years. This shows that the average annual cost to the state of providing free care for anyone in residential care for more than two years is estimated at around £800 million, and the average annual benefit to the individual is estimated at £900 million (note that these estimates are mid-points from a possible range). The net benefit of providing this commitment is therefore estimated at around £100 million per year. This net benefit is the value that free care after two years in residential care provides in terms of providing certainty to the individual, i.e insurance. These costs are shown in the second *Summary: Analysis and Evidence* cover sheet.

The costs and benefits over the period 2016/17–2025/26 consider the implementation of a comprehensive National Care Service, with universal deferred payments for accommodation

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<sup>1</sup> Department of Health, 2008 *The case for change – why England needs a new care and support system*

costs in residential care and increased use of advocacy services<sup>2</sup>. The total average cost over the period 2016/17-2025/26 is estimated at £4,440 million per year, and the total average benefit to the individual is estimated at £5,520 million per year. The average net benefit is therefore estimated at around £1,080 million per year. The net benefit is the value that state provision provides in terms of certainty to the individual, i.e. insurance, the distributional adjustment, i.e. the benefit of providing more resources to the relatively less wealthy, and the possible cost savings to the NHS of increased social care activity. These benefits are discussed further within this Impact Assessment.

It has not been possible to monetise all the benefits of free care for anyone in residential care for more than two years and a comprehensive National Care Service. It has not been possible, for example, to monetise the psychological, or other benefit, to carers.

Note that all cost and benefit projections are necessarily based on assumptions about the future, and therefore subject to some uncertainty. The uncertainties around estimates are also discussed in some detail in this Impact Assessment.

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<sup>2</sup> Note that the costs over 2016/17-2025/26 implicitly encompass the costs of free care for anyone in residential care for more than two years for residential care, since care costs in residential care would be covered under the comprehensive National Care Service.

**Table 1 Summary of one-off and average annual costs of the White Paper, 2009/10 prices**

Policies with Monetised Costs	One off costs	Average annual cost	
	Various over period 2011-2016	2014/15-2015/16	2016/17 - 2025/26
	(£m)	(£m)	(£m)
<b>Delivering the Vision of the National Care Service</b>			
Online portal for National Care Service	0.9-1.2		
Increasing use of Advocacy Services			0.1
<b>Embedding Quality in the National Care Service</b>			
Joint outcome indicators	£12.5-£16.5k per indicator		
<b>Fair Funding</b>			
<b>Comprehensive as a long term vision</b>			
Net cost to the state of Comprehensive			4,400**
<b>Free care for anyone in residential care for more than two</b>			
Net cost to the state of providing free care for anyone in residential care for more than two years		800	
<b>Accommodation costs</b>			
Universal deferred payment mechanism			40
<b>Total</b>	<b>One-off costs not fully monetised*</b>	<b>800</b>	<b>4,440</b>

\*There will be additional one-off costs of implementing the National Care Service, not monetised or considered in the table above. Due to uncertainty around the details of implementation (to be decided by the National Leadership Group and Government Commission on Care and Support), all one-off costs have not been monetised in this Impact Assessment

\*\* These costs relate to Comprehensive without treatment of AA/DLAc standardised across local authorities. These costs may therefore change when policy details on AA/DLAc standardisation have been finalised.

The following table summarises the estimated benefits of reforms to the social care funding system.

**Table 2 Summary of one-off and average annual benefits of the White Paper, 2009/10 prices**

Policies with Monetised Benefits	One off benefits	Average annual benefit	
	Various over period 2011-2016	2014/15-2015/16	2016/17 - 2025/26
	(£m)	(£m)	(£m)
<b>Fair Funding</b>			
<b>Comprehensive as a long term vision</b>			
Net benefit to individuals of Comprehensive			5,500 **
<b>Free care for anyone in residential care for more than two years</b>			
Net benefit to individuals of receiving free care for anyone in residential care for more than two years		900	
<b>Accommodation costs</b>			
Universal deferred payment mechanism			20
<b>Total</b>		<b>900</b>	<b>5,520</b>

\*\* These costs relate to Comprehensive without treatment of AA/DLAc standardised across local authorities. These costs may therefore change when policy details on AA/DLAc standardisation have been finalised.

Note that the present value of total costs and benefits presented on the *Summary: Analysis and Evidence* pages are discounted at 3.5 per cent per annum, from 2009/10.

This is a long-term vision and we recognise that costs will need to be continually refined as we move towards implementation. This includes refining whether the changes to be implemented will result in new burdens to local authorities so that they are appropriately funded to deliver services. This will all need to be factored into discussions at any future spending review. The analysis only considers the *additional* costs and benefits of reform proposals.

This Impact Assessment builds on the Impact Assessment produced to support the Green Paper *Shaping the Future of Care Together*, published 14 July 2009. Policy proposals have also considered the outcome of the 18-week formal public consultation undertaken following publication of the Green Paper, to which over 28,000 formal responses were received.

# 1. Background – case for change

The social care system was not part of the reforms that led to the creation of the NHS in 1948, and historically the state only provided support for people who had no family and could not afford to take care of themselves. Life expectancy was also shorter at this time and some conditions that are now common were unknown.

Over time the care and support system has been responding to changing society and changing needs. There have been many improvements in the last 20 years. Reforms already underway are delivering real benefits. However, the next 20 years will involve challenges on a scale that has not been seen before.

## The care and support system today

People who have a social care need may receive care in three ways:

- state-funded, where people approach their local authority and, following assessment the local authority pays for all or some of their care and support
- self-funded, where people buy their own care privately from agencies or individual providers (a small proportion of people may pay for their care privately but have it organised by local authorities)
- informal, where people are cared for by friends or family. Many people who are also receiving the types of formal care highlighted above will also receive additional informal care.

State social care is funded through a combination of central government grants, council tax revenues, and user charges.

Local authorities decide how to prioritise that funding and how much of it to spend on social care. To decide who should receive social care funding, local authorities have a legal obligation to assess individuals who approach them for an assessment. Assessments are based on two criteria:

- needs, which are assessed using national guidance on eligibility criteria for social care<sup>3</sup>. Users may be assessed as having low, moderate, substantial or critical needs
- means – income and assets. If the individual's needs and wishes result in a plan for residential care (i.e. care in a care home), the assessment includes the value of any property they own unless a dependent also lives in the property. Means-testing is also applied to care in the individual's home.

Local authorities' response to need is also not standardised.

- Local authorities can set eligibility criteria for community or home care in line with local priorities. Local authorities are also able to set their own charging regimes within national guidelines<sup>4</sup>.
- Local authorities set their own eligibility criteria for residential care but must comply with a nationally-set charging system. Only people with assets of less than £23,000 (including the

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<sup>3</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_113154](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113154)

<sup>4</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/LocalAuthorityCirculars/AllLocalAuthority/DH\\_4004736](http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/LocalAuthorityCirculars/AllLocalAuthority/DH_4004736)

value of any property) are eligible for state-funded residential care. Below this there is a standardised system of charging for residential care. Since residential fees cover accommodation costs, publicly-supported residents are required to contribute most of their income through user charges (other than specified exemptions, for example £21.90 per week for the personal expenses allowance).

Increasingly local authorities are setting eligibility criteria so that only people who have assessed needs in the highest categories (critical and substantial) are eligible for state funding, depending on further means tests assessing their ability to pay for their care. Many people do not get help from the state towards paying for their high-level care and support needs either because their income is assessed as being too high to qualify for state support or because their needs are assessed as too low to qualify for state support.

The state also provides some national benefits to contribute to the extra costs of disability. The main benefits are Attendance Allowance (for people over 65) and Disability Living Allowance (available to people if they claim before they are 65). Both of these benefits are delivered directly into people's bank accounts as a cash sum.

Care provided can be either in the community (e.g. for people at home) or residential care, where people move to the accommodation in which their care services are delivered. Services are delivered by a combination of the public, private and voluntary sectors, although increasingly the role of the public sector is as care arranger rather than provider<sup>5</sup>.

### Issues with the current system

Although reform of the care and support system is already underway there remain problems to be resolved, some of which cannot be resolved without significant reform. The problems raised by people most frequently during the Government's engagement programme in 2008 and consultation in 2009 were that:

- state-funded care and support is often provided only when people have already developed high levels of need
- people with the same needs receive different levels of care depending on where they live
- the different parts of the care and support system do not always work well together
- the system as a whole is confusing, with people not being clear about what makes up 'care and support' or what financial support they may be eligible for or entitled to
- the system is not designed to meet people's individual needs
- if many people with high needs do not get help from the state towards paying for their care and support, people can feel the system seems unfair and does not offer peace of mind.

Reform in recent years has begun to change people's experience of the system for the better and ensure that people with a care need are treated with dignity and respect. For example: the Disability Discrimination Act 1995 has been strengthened by the Government to give disabled people enforceable rights in all areas of life; the introduction of direct payments and personal budgets, led by campaigning from disabled people has given people with a care need more control of their care; and Putting People First supporting local authorities in transforming systems and making care services more personalised.

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<sup>5</sup> For example, the proportion of home care contact hours provided by the independent sector has risen from 42 percent in 1998 to 81 percent in 2008 (NHS Information Centre for health and social care, Community Care statistics: Home Help/Home Care statistics).

However, we know that we need to do more. We are also beginning to see wider socioeconomic and technological changes that will pose huge challenges to the care and support system.

## Future challenges

### *Demographic change*

The pace of demographic change is a pressing challenge. Improvements in healthcare, quality of life and lifestyle mean we are all living longer. There will be a substantial increase in the number of people requiring care and support over the coming years. The Government expects the number of disabled younger adults and older people with potential care needs to rise from under 6 million now to around 7.66 million in 2030, an increase of around 1.7 million over 20 years (Wittenberg et al 2008).

We are also seeing a shift in the proportion of people of working age compared to those over retirement age. In 2008, there were 3.2 people of working age for every person of State Pension age. This old age dependency ratio is projected to fall to 2.8 by 2033, taking into account the future changes to the State Pension age<sup>6</sup>. While it is important to recognise that not all care recipients are aged over 65, nor are all tax payers and care providers aged under 65, dependency ratios are a useful way to illustrate the changing age distribution of the population.

The proportion of people who are working compared with those who are in retirement is shrinking. This has implications for the workforce and who pays for care, particularly around:

- where the people to look after the ageing population will come from if the working population is becoming smaller
- considering fairness between generations as it will become increasingly unsustainable to rely on the reducing proportion of the population who are working to pay for care.

### *Changes in technology*

We can also expect to see a change in the way care and support is provided. Technologies are already entering the care and support system. For example, remote digital cameras enable care workers to see and talk to a person regularly throughout the day while monitors can sense if people are out of bed for extended periods and inform staff for people who are at risk of falls to ensure prompt action is taken. It is fair to assume such advances will continue and the care and support sector will need to be positioned to take advantages of such innovations.

### *Changes in expectations*

People have rising expectations of publicly-provided services, including the care and support system. We expect higher standards and greater choice over our lives than our grandparents did, and our children are likely to expect more than us. People want a system that meets their needs whatever age they are, and that recognises that people's priorities can change during the course of their lives. The support people receive should be flexible and adaptable to suit different needs, should keep them safe if they are in vulnerable situations, and should give them as much control as possible over their own care. These changes in expectations will continue to be a key driving force for reform to care and support in the future.

The economic situation in England and across the world has changed radically in recent years. Future economic projections for the short and medium term look very different to when the

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<sup>6</sup> ONS, 2008-based national projections

current debate around care and support began. The proposals in the White Paper considered in this Impact Assessment must take account of these economic circumstances without backing away from the bold reform needed.

This makes clear that the care and support system needs to be reformed if it is to be able to resolve current issues and meet the demands of the future. Without reform, it is likely that families will be under pressure to provide increasing levels of care and that some adults potentially go without the care and support they need. The system will also fail to provide dignity and a good quality of life for increasing numbers of people and may trigger growing demand for NHS services (for example emergency admissions) as a result.

## 2. Background – case for Government intervention

The rationale for Government intervention was considered in more detail against the alternative of removing state support entirely, i.e. a purely private solution, in the Impact Assessment for the Care and Support Green Paper. This included the impact on equity and efficiency within the care and support system.

Government intervention through a state system pooling risk across the population is needed to help ensure that:

- people with care and support needs have access to the support they need to stay as well as possible for as long as possible
- people with care and support needs have a greater opportunity to achieve the outcomes they want
- caring for friends or family with care and support needs would be less likely to prevent a person from having the opportunity to achieve other outcomes, for example by making it more difficult to remain in paid employment or reducing social interaction.

Government intervention also provides opportunities to promote equity, efficiency and cost effectiveness, as outlined in the Impact Assessment for the Care and Support Green Paper<sup>7</sup>.

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<sup>7</sup> <http://careandsupport.direct.gov.uk/greenpaper/the-green-paper-and-supporting-documents/>

### 3. Objectives for this Impact Assessment

The White Paper *Building the National Care Service* announces that the Government commits to a comprehensive National Care Service that will be for all adults in England with an eligible care need, free when they need it. The National Care Service will not be a single organisation or institution but a partnership between the individual, their families and carers, communities, providers and the state. It will not replace the care that many people receive from their families, friends and communities; but it will support those receiving and providing care enabling people to remain active, contribute to their communities and the economy, and enhance their own wellbeing. The proposals for building the National Care Service apply to England only.

To manage the impact on public finances and ensure that the National Care Service is affordable and sustainable, the White Paper outlines that it needs to be built in stages. This is also in recognition of the significant changes that will be required to the system to make the vision of the National Care Service a reality.

The first stage is to create a step change in the provision of services in the home and in communities. These services are essential if we are to ensure more people are supported in their homes, and that costs in the system are to be controlled. Central to this is the Personal Care at Home Bill, helping the most vulnerable first, enabling us to provide free personal care in their own homes for those with the highest needs. The first stage of reform will also see the creation of re-ablement services available in every community ensuring there is a service by which people can be supported to regain their independence and confidence when they need home care for the first time. As part of the first stage we will also see through existing reforms that are already delivering real benefits for people such as the dementia strategy, carers' strategy and *Putting People First*.

The second stage of reform, during the next Parliament, will be to put in place the building blocks of a national system of care and support, in particular the establishment of clear national standards and entitlements. The Government will establish a National Care Service Leadership Group by July 2010 to provide expertise and support delivery of the National Care Service. The group will advise the Government on a detailed implementation plan by the end of 2010. The Government will introduce a National Care Service bill early in the next Parliament as a major step forward. From 2014, care entitlements will be extended meaning that anyone staying in residential care for more than two years will receive free care after the second year. The first and second stage together will mean that the most vulnerable in society, those with the highest needs, will be protected from very high care costs and that many more people will be supported in their own homes. People on low incomes will continue to have all of their care costs paid by the state.

At the start of the next Parliament, the Government will establish a commission to help to reach consensus on the right way of funding a comprehensive National Care Service. The Commission will determine the fairest and most sustainable way for people to contribute. It will make recommendations to Ministers which, if accepted, will be implemented in the Parliament after next. It will determine the options which should be open to individuals so that people have choice and flexibility about how they pay their care contribution. The expectation is that the Commission will consider all the various options for payment put forward by stakeholders and the public as part of the Big Care Debate and at the Care and Support Conference held on 19 February 2010. The Government will be clear about the principles it wants the Commission to consider, such as fairness to all including between generations.

The National Care Service will then be established on the back of a clear national consensus on how individuals are required to contribute.

The final stage of reform, after 2015 will then be an affordable comprehensive National Care Service for all adults in England with an eligible care need, free when they need it, whoever they are, wherever they live and whatever condition leads to their need for care. Underpinning this stage will be sustainable and fair funding backed by a mandate from the public. At this point the Government will take forward the proposals of the Commission on how people should make their contributions to the system to ensure that the National Care Service is sustainable and provide high quality care for generations to come.

The summary sheets are for building a comprehensive National Care Service for all adults in England with an eligible care need, free when they need it.

The funding system, and supporting systems and processes are covered in this Impact Assessment under the following headings.

### **Delivering the vision for the National Care Service**

- Prevention and wellbeing services to keep people independent.
- Nationally-consistent eligibility criteria for social care enshrined in law for the first time.
- A joined-up assessment.
- Information and advice about care and support services.
- Personalised care and support through a personal budget.

### **Embedding quality in the National Care Service**

- The National Care Service to have an independent body to develop national quality guidance on best practice for the most cost-effective interventions and act as a knowledge bank for the sector.
- Developing a national quality framework for the National Care Service.
- Developing a more integrated and aligned health and care and support system through looking to introduce mandatory shared outcome indicators and joint commissioning in line with priorities from the Joint Strategic Needs Assessment (JSNA).
- Setting up a regional demonstrator site for a licensing scheme for all social care workers and healthcare support workers.

### **Fair funding**

- Reforming the funding system for adult social care.
- Providing a locally-determined funding system with national consistency.
- Supporting people with accommodation costs through a universal deferred payments scheme.

A number of reform proposals were presented in the Impact Assessment for the Care and Support Green Paper. This Impact Assessment does not repeat the option analysis in detail as it remains publicly available. This Impact Assessment focuses on analysis of the costs and benefits of final policy options.

The specific impact of the final proposals on key equality strands – age, gender, disability, sexual orientation, faith/belief, race – are considered more fully in a separate Equality Impact

Assessment, that also considers the proposals in light of key human rights elements. This will be available at <http://careandsupport.direct.gov.uk>

The Personal Social Services Research Unit (PSSRU) at the London School of Economics (LSE) undertook modelling for the Government on the scale of demographic change, the financial pressures that this represents for social care and other services for people with care and support needs, and the options for change, using particular methodology for older people and for younger adults (Wittenberg et al, 2005 and Wittenberg et al, 2008).

The modelling work that informs much of the data and analysis in this Impact Assessment is described further in Annex B of this Impact Assessment.

The vision set out in the White Paper is a long-term vision. It will require regular refinement of costs as we move towards implementation, building on recommendations for proposals and further understanding potential new burdens for local authorities. It will be particularly important to ensure that the financial implications of decisions on eligibility criteria are carefully analysed and that those decisions are consistent with the resources that will be available following the work of the Commission on financing a comprehensive National Care Service. It will need to be factored into discussions at any future spending review. The Government will be working with the National Care Service Leadership Group, which will include the sector, to refine the approach to implementation and understanding of the costs.

## 4. Delivering the vision for the National Care Service

### Prevention and wellbeing services to keep people independent

The Impact Assessment for the Care and Support Green Paper highlighted the current challenges relating to access to and provision of interventions that could be considered as preventative. A number of options for reform were presented. Feedback from the consultation process highlighted that respondents strongly agreed with the importance of the preventative agenda for the National Care Service supporting people to live independently and well.

#### *White Paper policy option*

The National Care Service will build on the key principle of prevention to keep people well and independent. The White Paper announces that:

- where particular interventions work and are affordable the Government wants local authorities to ensure that everyone can benefit quickly – an independent body will make recommendations on effective preventative interventions in terms of cost-effectiveness and outcomes, producing national guidance to be disseminated to support local authorities, PCTs and providers in delivering effective outcomes
- re-ablement will be free for everyone who could benefit from it when they need home care for the first time. This will help them to regain their independence.

#### *Costs and benefits of the White Paper policy option*

Providing quality guidance and recommendations on cost-effective preventative interventions will be undertaken by an independent body and is covered later in this Impact Assessment. It is also expected there may be additional costs in creating useful information and advice relating to the evidence base. This is covered in the wider section on information and advice available later in this Impact Assessment. The White Paper makes no additional commitments on re-ablement to what has already been considered in the Impact Assessment to support the Personal Care at Home Bill<sup>8</sup>. Consequently, this Impact Assessment only considers an analysis of the costs and benefits for investment in preventative interventions.

#### *Costs*

Recommendations and guidance on the cost-effectiveness of interventions and the effectiveness of outcomes will be made by an independent body. No specific interventions are considered in the White Paper.

There may be additional costs in providing cost-saving preventative interventions, for example set-up costs, staffing and training, although such costs may be recouped in later years through savings realised. Consideration would need to be given on how and whether individual interventions would place an additional administrative burden on local authorities and consequently, whether additional central funding would be necessary to deliver these. This cannot be quantified until individual interventions are recommended by the independent body.

Effective joint working is likely to be important in delivering effective preventative services. An analysis of the costs and benefits is considered in later sections of this Impact Assessment on

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<sup>8</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH\\_109140](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_109140)

developing a more integrated and aligned health and care system.

## *Benefits*

### Benefits from investment in preventative interventions

It will be for local authorities to determine how they achieve the outcomes from recommended interventions, and guidance will only be produced if intervention is determined to be cost-effective. It is assumed that wider benefits will accrue, such as enhanced quality of life from improved health, reduced morbidity and reduced need levels for service users. This will vary according to the nature and outcomes of the individual services funded.

The findings of the national evaluation of Partnerships for Older People Projects (POPP) programme<sup>9</sup>, which looked at developing services for older people aimed at promoting their health, wellbeing and independence findings indicate that the projects as a whole had a potential to improve the quality of life for participants and the potential for considerable savings, as well as better local working relationships. For example:

- for every £1.00 spent on the POPP services, there was a marginal cash saving of £1.20 on emergency bed days (confidence interval £0.80 to £1.60). In addition, there were estimated to be savings in use of community services and reported improved quality of life which have not been monetised
- overnight hospital stays were reduced by 47 percent and use of accident and emergency departments by 29 percent
- reductions were also seen in physiotherapy/occupational therapy and clinic or outpatient appointments with a total average cost reduction of £2,166 per person
- efficiency gains in health service use appeared to have been achieved without any adverse impact on the use of social care resources
- the quality of life of those using services were reported as improved, to varying degrees depending on the nature of individual projects
- 79 per cent of respondents agreed that partnership working between the local authority and voluntary and community sector providers had been improved.

This evaluation indicates the potential for a range of such projects and services having a positive impact both on outcomes for individuals and cost-effectiveness for local services.

## ***Groups affected***

Everyone should benefit from prevention and wellbeing services. For those with a low-level need or a specific incident, services can prevent needs escalating further, and for those with existing high levels of needs services may offer enhanced quality of life and support people to remain at home for longer.

## **Nationally consistent eligibility criteria for social care enshrined in law**

### **A joined-up assessment**

For the purposes of the Impact Assessment, both of these key pillars of the National Care Service are considered together. The Green Paper Impact Assessment highlighted key issues around portability and lack of consistency in the approach to assessment for social care.

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<sup>9</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_111240](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111240)

Options for reform were also presented. Feedback from the consultation process highlighted widespread support for a national assessment process to ensure consistency for everyone, regardless of where they live. Respondents also raised the need for regular re-assessment to take fluctuating needs into consideration and a need to avoid the risk of 'pigeonholing people' through one standard, inflexible assessment.

### ***White Paper policy option***

The White Paper announces that the Government wants to move towards creating a joined-up process that will give access to care and support services. This will begin by aligning the referral processes for social care and Attendance Allowance. The Government will also ask the National Care Service Leadership Group to look at whether and how the gateway for accessing social care and disability benefits could be improved.

The White Paper also outlines that there will be nationally consistent eligibility criteria for social care enshrined in law for the first time, which sets the point at which someone becomes eligible for state support in England. If someone moves to another part of England, they will be able to take the results of their assessment with them, unless they want a re-assessment because their circumstances have changed. The Government will ask an independent group of experts, as part of the National Care Service Leadership Group to advise Ministers on the design of the eligibility criteria for social care and also look at the case for moving towards more aligned eligibility across a wider range of services and disability support, including considering how this might be done. The White Paper outlines the Government will consult on the criteria before they are implemented.

### ***Costs and benefits of the White Paper policy option***

Further costs and benefits of any development in the assessment process or alignment of eligibility for care and disability support will be subject to analysis once any recommendations from the National Care Service Leadership Group are received.

#### *Costs*

Costs and benefits for the eligibility criteria cannot be quantified at this stage as it is dependent on recommendations from experts in the National Care Service Leadership Group. A portal for referral process is covered in the later section on information and advice as an element of the national portal.

#### *Benefits*

- Accessing care and support will be simpler for people. People will automatically get information about how to apply for social care and disability support.
- Being able to transfer the results of a needs assessment from one location to another will remove huge barriers to portability which people are currently facing.

### ***Groups affected***

This policy will affect people over 18 years of age who seek, or are referred for assessment for care and support. The assessments will be based on nationally consistent eligibility criteria for social care in England, which will be defined during implementation of the policy proposal. Such national consistency and transparency should have a positive impact on all groups in providing a better understanding of access to care and support.

## Providing information and advice about care and support

Good information and advice is important in ensuring that people can access the services to which they are entitled. The Green Paper Impact Assessment acknowledged there are issues with current provision and presented options for reform. Responses to the Consultation highlighted the need for more pro-active information and advice, more consistency in the quality of the information and advice provided, and a concern that people in need of services were not always aware these services were available to them.

While the Government feels that the creation of one National Care Service will provide greater clarity to people around what care and support is, and what they are entitled to within that, it wants to further ensure and embed this by building on the options set out in the Green Paper.

### *White Paper policy option and objectives*

The White Paper encourages more organisations to make use of the Information Standard<sup>10</sup>, a scheme established by the Department of Health which certifies that the information and advice provided by organisations is trustworthy.

The White Paper also announces:

- a national online portal for the National Care Service will be established
- the National Care Service Leadership Group will review information provision and set out what information all local authorities should be providing.

### *Costs and benefits of the White Paper policy option*

The Information Standard is already in place and the White Paper does not propose any changes to that scheme, consequently no additional costs or benefits are considered here.

The provision of universal information and advice to all individuals and carers, regardless of whether they receive state funding or fund their own care is a key part of the system redesign outlined in Putting People First (supported by £520 million ring-fenced Social Care Reform Grant for 2008-2011). No additional costs and benefits are therefore considered here.

It would be for the National Care Service Leadership Group to make any further recommendations on what information and advice people may require at a local level following its review of information and advice provision. If the group was to make specific additional recommendations further Impact Assessments may need to be completed to support implementation of such proposals.

### *Costs*

#### Costs for the online information portal

The potential costs for the online portal vary depending on how much functionality we want the website to have. Below are indicative costs based on the launch of the NHS choices website. The roll out of the NHS choices website was broken down into two components, design and development (phase one) and maintenance and evolution (phase two).

Phase one is estimated to cost between **£0.9 million and £1.2 million** at the maximum end of the range (2009/10 prices) and consists of programme management and business analysis; concept exploration; customer insight and research; user experience and design; data and

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<sup>10</sup> [http://www.dh.gov.uk/en/Healthcare/PatientChoice/BetterInformationChoicesHealth/Informationstandard/DH\\_098427](http://www.dh.gov.uk/en/Healthcare/PatientChoice/BetterInformationChoicesHealth/Informationstandard/DH_098427)

directory development; content strategy and creation; development and quality assurance; integration and release management; and marketing plan. This will include developing a single portal element of the referral process as outlined in the section on eligibility and assessment.

Phase two consists of hosting and support; and future content and functionality and implementing the referral system. The costs of this phase are yet to be determined. Post-site launch costs will need to be factored into the overall costs for the portal. Costs will be determined by site enhancements and support. We will need to ensure that information is available in a range of languages. Costs of translation will depend on the content of the portal.

### Advocacy services

The White Paper refers to the statutory advocacy services already should be provided, details of which are set out in the Mental Capacity Act 2005<sup>11</sup>. These are formal, paid-for advocacy services which are offered to those who need assistance in making decisions about their care and do not have suitable friends or family who can help them. In implementing a comprehensive National Care Service that may increase the number of people receiving care and considering natural population growth, we estimate that more people may require these statutory advocacy services.

In 2008/09, 6,582 people used an Independent Mental Health Advocate (IMHA). Applying the natural rate of population growth to this figure for illustrative purposes, gives a projected figure of 6,960 people using IMHAs by 2016/17, illustratively. The Personal Social Services Research Unit<sup>12</sup> estimates suggest a 35.8 per cent increase in the number of scheme recipients (in the care and support system) in the comprehensive National Care Service compared to the current means testing system. However, people who receive advocacy services are likely to have high levels of need and therefore are likely to be receiving some form of care already – and already accessing advocacy services. Therefore, we have estimated the cost of the service assuming half of this increase in demand for advocacy services. This would equate to a cost of around **£110,000** in 2016/17, illustratively (in 2009/10 prices). Over a 10 year period (up until financial year 2025/26), real costs are estimated to be around **£1.0 million** (in constant 2009/10 prices).

### *Benefits*

We expect that ensuring everyone is aware of the National Care Service and what it can offer should have a positive impact on health and quality of life and the provision of quality local information and advice should enable people to make appropriate decisions around the care and support they need to access .

### **Groups affected**

We think by taking a more proactive approach to giving people information and advice, we will benefit all groups, as we will be reaching out to try and ensure we cover everyone.

The information and advice around the National Care Service should be accessible and relevant for everyone: care users, carers, the friends and families of those needing care, and people who want to plan for their future and that of their families, should all find this information easy to use and helpful.

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<sup>11</sup> [http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityAct2005/DH\\_073511](http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityAct2005/DH_073511)

<sup>12</sup> <http://www.pssru.ac.uk/index.php>

## **Personalised care and support through a personal budget**

### ***White Paper policy option***

The White Paper announces that every eligible person will be offered a personal budget by the time the National Care Service is introduced. People may choose to take some or the entire personal budget as a direct payment in cash instead of services. This will need to be supported by effective risk management with reasonable and proportionate scrutiny. This supports the Government's commitment to offer people more control and choice over the care and support they access.

### ***Costs and benefits of the White Paper policy option***

The White Paper makes no additional commitments beyond those of Putting People First (which was supported by the ring-fenced Social Care Reform Grant for councils from 2008-2011). Consequently, there is no analysis of additional costs and benefits.

### ***Groups affected***

All adults with eligible needs will be able to find out how much money is being dedicated to providing their care and support. This is the size of their personal budget, giving them more choice and control over their care. Even if someone chooses not to take a direct payment in cash they will be able to discuss with their local authority how their money will be spent on their behalf. Since 2009, special arrangements have been put in place for people who lack mental capacity to be able to benefit from direct payments in cash too.

## 5. Embedding quality in the National Care Service

The Green Paper Impact Assessment considered options for reform in terms of a need for a wider range of services, more joined-up services and improved quality and innovation. There is already a great deal of work ongoing in this area, driven by the Putting People First concordat, and the sector is making progress.

Information from the Care Quality Commission on quality suggests that many areas of social care are already performing well (CQC, 2009). However, the Consultation highlighted that the quality of care was a major concern to many people and stakeholder organisations. Variations in the quality of care and the outcomes delivered because of people's geographical location were deemed unacceptable. There was widespread support for the three options of reform outlined in the Green Paper: a need for a wider range of services; more joined-up services; and improved quality and innovation. Following this, Government listened to these concerns and decided a step change in quality was required in order to meet the Government's objectives.

### ***White Paper policy proposals***

The White Paper therefore announces that:

- there will be an independent body for the National Care Service to produce national quality guidance on effective and cost-effective interventions and act as a knowledge bank for the sector
- a more integrated and aligned health and care and support system will be developed with a new duty for local authorities and NHS bodies to deliver services in an integrated manner. Part of this will be looking at the case for introducing mandatory shared outcome indicators across local authorities and PCTs and a statutory duty for local authorities and PCTs to commission jointly in line with priorities set out in the JSNA
- a quality framework for care and support will be developed, which will complement the NHS quality framework
- a regional demonstrator site will look at a licensing scheme for all social care workers and healthcare support workers.

In many areas, local authorities and PCTs have brought together their leadership and appointed joint boards and chief executives. Other areas have chosen to jointly commission, while others have pooled budgets. The Government recognises that different approaches are required for different areas, but wants all local areas to deliver improved services and outcomes for their populations, and believes working more closely together across the health and care boundary is critical to achieving these outcomes.

The White Paper does not provide specific details of implementing these proposals – for example no decisions have been made regarding which bodies will take on the different roles within the National Care Service and we need to work with the sector to ensure we have credible and valuable indicators in place that will reflect shared outcomes across health and care services. Further work to determine this will be taken forward as part of implementing the National Care Service, including appropriate Impact Assessments to analyse the costs and benefits of specific proposals. If any mandatory indicators are determined they will be introduced via the performance frameworks for the NHS and local authorities.

## **Costs and benefits of the White Paper policy options**

### **The National Care Service to have an independent body to produce national quality guidance on effective and cost-effective interventions and act as a knowledge bank for the sector**

#### *Costs*

The costs of an independent body will depend on the volume and types of guidance it is commissioned to produce. Decisions around this will be made during development of the quality framework in conjunction with the sector.

For illustrative purposes, this Impact Assessment has examined the costs of producing National Institute for Health and Clinical Excellence (NICE) guidance, as these may provide some indication of the likely costs of the independent body. NICE Annual Reports and Business Plans show that during the period 2007/09, NICE produced 182 items of guidance, and during 2009/10, it was planning to produce 88. These include technology appraisals, interventional procedure guidance, public health guidelines and clinical guidance. The average cost per item over these three years was approximately £210,000 (in 2009-2010 prices). These costs are calculated by dividing the annual budget for the centres in NICE that produce guidance by the number of items of guidance produced. They do not include overheads such as management, communications and business planning. If these are included the cost approximately doubles, to £416,000.

The cost per item varies, depending on the type of guidance produced. The cost ranges from approximately £70,000 per item (£140,000 including overheads) for technology appraisals and interventional procedures guidance to approximately £620,000 per item (£1.2 million including overheads) for public health guidelines, as shown in the table below.

**Table 3 Estimated costs of NICE guidance, by type (2009-10 prices)**

<b>Type of Guidance</b>	<b>Average direct cost</b>	<b>Average cost including overheads</b>	<b>Items of guidance 2007-2010</b>
<b>Technology appraisals and interventional procedures</b>	<b>£70,000</b>	<b>£140,000</b>	<b>196</b>
<b>Clinical guidelines</b>	<b>£550,000</b>	<b>£1,100,000</b>	<b>51</b>
<b>Public health guidelines</b>	<b>£620,000</b>	<b>£1,200,000</b>	<b>23</b>
<b>All guidance</b>	<b>£208,000</b>	<b>£416,000</b>	<b>270</b>

It is not known which type of guidance most closely resembles the guidance the independent body will produce, as decisions have not yet been made on this. It is possible that the cost per item will also vary depending on the volume of guidance produced. There may also be set-up costs in addition to the ongoing costs of producing guidance.

The level of set-up costs and overheads is likely to depend on the organisation chosen to perform this role, and this decision will be taken in the light of future spending reviews and the review of arms' length bodies currently being taken.

The costs set out here do not include the costs of implementing recommendations contained in any guidance. The costs and benefits of implementing such recommendations would need to be determined when guidance is produced.

## *Benefits*

Specific benefits of national quality guidance will depend on the individual guidelines produced. In broad terms, it is expected that the independent body to play a role in 'mainstreaming' best practice, so the benefits should be improved care and outcomes for people, delivered in a cost-efficient way.

## **Develop a more integrated and aligned health and care and support system**

The White Paper considers some very specific policy objectives for improving integration. This Impact Assessment specifically looks at an analysis of costs and benefits of those proposals. Some current evidence does suggest that closer joint working has the potential to lead to more significant benefits (Glasby, Ham et al, 2010) and there are some specific local examples of good practice. As we move forward with implementation of the White Paper proposals, we will need to explore further any such benefits from integration. This will need to be done in partnership with the National Care Service Leadership Group and the efficiency taskforce.

## Looking to introduce shared mandatory outcome indicators

### *Costs*

For illustrative purposes, it is suggested that the costs of any mandatory indicators fall into three categories: indicator development, ongoing maintenance, and enhanced cooperation arising from the indicators.

The costs involved in developing new indicators would be borne by central government. Analysis of cost data on indicator production supplied by the NHS Information Centre suggests that it costs approximately £4,500–£5,500 to develop a new indicator. Some indicators are more costly than others. For example, the complexity of statistical methodology will vary across indicators. More complex indicators are likely to be more time-consuming to construct and therefore more expensive. The exact cost will therefore depend on the indicators chosen.

In addition to these costs, central government may incur costs in managing the development of the indicators, including discussion with appropriate stakeholders. Local authorities and PCTs may incur costs in providing feedback on the indicators. The costs to central government are estimated at £5,000 and the costs to local organisations are estimated at £3,000–6,000 in total, depending on the number of organisations that provide feedback. The total development cost of each new indicator is therefore estimated at £12,500–£16,500.

The ongoing maintenance costs involved in the assessment of performance against indicators and publication of results are also likely to be borne by central government, on the assumption that there are no new datasets requiring local input. Figures supplied by the NHS Information Centre suggest that these ongoing annual costs are approximately £900–£1600 per indicator. However, if new mandatory indicators are replacements for existing indicators and the total number of indicators is unchanged, the total cost of maintenance should also be unchanged from current levels. If, however, there were new data collections there would be ongoing (and potentially substantially higher) costs.

The purpose of new indicators is to encourage greater cooperation between local authorities and the NHS in order to improve the quality of services for users. Enhanced cooperation is likely to entail costs as well as benefits. If the indicators play a part in encouraging this cooperation, it is reasonable to attribute some of the costs and benefits to the indicators. However, the response at local level will depend on which indicators are chosen. It is not possible therefore to

estimate costs and benefits at this stage. If any mandatory shared outcome indicators are used, they will be included in performance frameworks for both local authorities and the NHS.

### *Benefits*

It is expected that any new shared mandatory outcome indicators will encourage joint working and incentivise the provision of higher-quality, better coordinated services for people. It is not possible to quantify the impact of these changes until any indicators are chosen.

### New statutory duty to commission jointly

#### *Costs*

Local areas will determine which services they wish to commission jointly through their JSNAs. They will also decide what form of joint commissioning is most appropriate to meet their objectives, based on their knowledge of local circumstances. This may involve pooled or aligned budgets, joint appointments or other forms of co-operation. Local organisations will need to assess the costs and benefits of individual proposals in deciding how best to implement joint commissioning for their populations.

Given that the costs (and benefits) of joint commissioning will depend on the priorities and the forms of joint commissioning selected locally, and are likely to vary across the country, it is not possible to estimate these costs with confidence at this stage.

#### *Benefits*

Local areas determine in their JSNAs where joint working would be helpful, and this process has proved effective in ensuring that local authorities and PCTs reach agreement on the priorities for their area. Requiring them to commission jointly for these services is an extra step that ensures this joint working becomes a reality.

It is not possible to quantify the benefits of the new statutory duty in advance of decisions by local organisations on priorities and forms of joint commissioning. Local organisations will need to assess the costs and benefits of individual proposals to inform decisions on priorities.

### **Groups affected**

It is expected that the groups most affected by these changes will be people who receive care and use services, who should experience an improvement in the quality of the services and a better coordinated service from health and social care providers.

People working in the NHS and in care may be affected by these changes, as they may need to work together in new ways. However, these changes reinforce initiatives already taken at local level. Local organisations already cooperate to produce JSNAs and a number of areas have pooled some budgets and developed other forms of joint working. These changes should provide impetus and support to help local organisations build on the progress already made.

## **Developing a quality framework for the National Care Service, complementing the NHS Quality Framework**

### *Costs*

The National Care Service Leadership Group will have a key role to play in the development of a Quality Framework. Any new policies arising from the development of the quality framework will be subject to further assessment. As part of working out how best to ensure quality within the National Care Service, and within the context of the arms' length body review, we will look at the functions the National Care Service needs specific bodies to complete.

### *Benefits*

Developing a quality framework that complements the NHS quality framework should provide clarity to the sector about what quality care looks like, and how best to provide it. It should ensure messages are joined-up from the centre about how we see health and care and support services working together, providing an integrated leadership approach. Ultimately, these changes should benefit people using care and support services by helping professionals work together around them to deliver high-quality services.

### ***Groups affected***

Those who work in care and support will be affected by this work, as will people using care and support services.

## **Setting up a regional demonstrator site for a licensing scheme for all social care workers and healthcare support workers**

The White Paper announces that the Government will set up a regional demonstration site for a licensing scheme for all social care workers and healthcare support workers. This will be the basis of a Learning for Quality scheme, in partnership with unions, workers and those who use care. Accreditation will be awarded by the Health Professions Council, renamed the Care Professions Council. Employers who can demonstrate that their staff are accredited by the Care Professions Council, and that they meet high standards of induction, training and supervision, will be kitemarked as Investors in Care.

The Government will consider the costs, and impacts of this scheme as part of the evaluation of the regional demonstration site. This will enable a detailed analysis of the costs and benefits of the scheme and will support consideration of how best to balance the burden on small businesses with the need to safeguard those receiving care services. Funding of the demonstration site will be considered as part of the detailed development of the scheme.

## 6. Fair funding

This section considers:

- the funding system for adult social care
- providing a locally-determined funding system
- accommodation costs

### The funding system for adult social care

#### *Current situation and options for reform as considered in the Green Paper*

In the Government's Green Paper, *Shaping the Future of Care Together*<sup>13</sup>, we set out five funding options: Pay for Yourself, Partnership, Insurance, Comprehensive and Tax-funded.

The Green Paper ruled out Pay for Yourself (on the basis that it was unfair that individuals who could not afford to pay for care would go without) and Tax-funded (on the basis that it would put too high a financial burden upon the decreasing proportion of the population that is of working age).

The three remaining funding options – Partnership, Insurance, and Comprehensive – all represented a major step forward in the provision of care and support.

With a Partnership option, everyone who qualified for care would be entitled to a set proportion – for example, a quarter or a third – of their assessed care and support costs paid for by the state. People who were less well off would have more care paid for – for example two thirds – while the least well off people would continue to get all their care for free.

An Insurance option would build upon the Partnership option, offering the opportunity for people to cover the additional costs of their care and support through insurance, if they wanted to do so.

A Comprehensive option would be for all adults in England with an eligible care need, free when they need it.

The public consultation demonstrated support for all three options outlined in the Green Paper. The Comprehensive option was the most favoured option by those who expressed a preference (41 per cent), with Partnership supported by 35 per cent and Insurance by 22 per cent.

The Insurance option has now been ruled out. This option received the least support in the public consultation. In addition, the private insurance market for care in England is very limited, following the near demise of an embryonic market in the 1980s. The situation is probably caused by both supply and demand side failures. Insurers have found it difficult to assess not only the uncertainty of future payouts, but also to define the criteria by which the payouts would be forthcoming. This creates adverse selection, i.e. the mix of individuals seeking insurance are weighted towards those enrolees with higher needs in a way that insurers cannot fully assess, which leads to under provision in the market and high insurance premiums. On the demand side, the potential high premiums result in low demand. Individuals may lack knowledge about the risk and extent of the costs of care and support and this may be exacerbated by a belief that ultimately the state will provide the services as insurer of last resort.

Uptake of voluntary insurance for the costs of care and support in the US (one of the only countries with an established voluntary insurance market for long-term care<sup>14</sup>) is in the region of

<sup>13</sup> <http://careandsupport.direct.gov.uk/greenpaper/the-green-paper-and-supporting-documents/>

10 per cent of all individuals aged 60 and over (Brown and Finkelstein, 2009: page 10). Low levels of take-up would mean that the risks of catastrophic costs would not be shared across everyone, and this would be likely to increase the costs of premiums. This would make voluntary insurance unaffordable for some. As a new funding system, voluntary insurance is therefore unlikely to solve the problem of individuals facing catastrophic costs for care.

### ***White Paper policy option and objectives***

After carefully considering the results of the consultation, the White Paper announces that the National Care Service should be based on the option that received the greatest public and stakeholder support - the Comprehensive option.

In the White Paper the Government commits to building a comprehensive National Care Service for all adults in England with an eligible care need, free when they need it.

The National Care Service will be built in three stages, building on the existing programme of reform and the best parts of the current system. This staged approach will mean the vital support that people need now can be provided, whilst the foundations for the National Care Service are put in place.

Analysis of the funding system for social care focuses on five options for reform.

Option 1 maintains the status quo.

#### **■ Option 1: do nothing**

##### *The long-term vision*

For the long-term vision, stage three of building the National Care Service, the focus is on two of the options put forward in the Green Paper, and therefore two of the options that we consulted on in the Big Care Debate: Partnership or Comprehensive<sup>15</sup>. These are options 2 and 3.

#### **■ Option 2: Partnership as the long-term vision**

#### **■ Option 3: Comprehensive as the long-term vision**

The preferred option for the long-term vision is Comprehensive.

Note that Options 2 and 3 do not consider any short-term funding options.

##### *The short-term vision*

However, we believe that there is an argument for providing the vital support we know people need now, as part of building towards a comprehensive National Care Service.

The option outlined in the White Paper is that people staying in residential care for more than two years will receive free care after the second year. The fourth option that we consider is therefore to provide free care for anyone in residential care for more than two years as of

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<sup>14</sup> Israel and France also operate employer-sponsored long-term care insurance markets.

<sup>15</sup> See above for reasons why we have ruled out Insurance, the third option presented in the Green Paper and consulted on in the Big Care Debate.

2014/15, followed by our preferred option for the long-term vision, Comprehensive. This short-term funding option provides vital support for those people who are particularly at risk of catastrophic care costs. This is Option 4.

■ **Option 4: Free care for anyone in residential care for more than two years, followed by Comprehensive**

*How we will consider Attendance Allowance and Disability Living Allowance (care component)*

Our preferred **long-term vision is Comprehensive**, with our **preferred short-term vision as free care for anyone in residential care for more than two years**.

The final option considered in the analysis of social care funding looks at the treatment of disability benefits when determining peoples care packages. This is option 5.

■ **Option 5: Free care for anyone in residential care for more than two years, followed by Comprehensive with possible improvements to the relationship between AA, DLA and social care**

Note that all options consider implementation of the Personal Care at Home Bill as part of the baseline situation. This would mean that free personal care is provided for 280,000 people with the highest care needs.

These various options are now outlined in further detail.

Option 1: do nothing

The do nothing option involves continuing the current system for care and support, including implementation of the Personal Care at Home Bill.

*The long-term vision*

As discussed, we consider two options for our long-term vision. These two options do not consider putting any short-term funding measures in place prior to implementation of the long-term vision.

Option 2: Partnership as the long-term vision

At implementation of Partnership, all adults in England who qualified for some care from the state would be entitled to have a proportion of their care and support costs paid for by the state (a quarter or a third – assumed to be a third in this analysis). People who were less well-off would have more care paid for on a sliding scale up to 100 per cent for the poorest and highest need groups in the population. People could then choose to pay a top-up themselves to make up the remaining proportion of their care. Note that it is assumed in this analysis that those people who will receive care under the Personal Care at Home Bill (subject to parliament) would continue to do so under this option.

For the purpose of analysis, we assume that implementation of Partnership would be in 2016/17.

### Option 3: Comprehensive as the long-term vision

At implementation of Comprehensive, all adults in England with an eligible care need will receive care, free when they need it.

Again, we assume that implementation of Comprehensive would be in 2016/17 for the purposes of analysis.

The White Paper announces that, based on extensive consultation feedback and an analysis of the costs and benefits of the options, the Government commits to put in place a comprehensive system. The **preferred long-term vision is therefore Comprehensive**. The White Paper also announces that a Commission will determine the fairest and most sustainable way for people to contribute. It will make recommendations to Ministers which, if accepted, will be implemented in the Parliament after next. It will determine the options which should be open to individuals so that people have choice and flexibility about how to make their contribution.

#### *The short-term vision*

### Option 4 – Free care for anyone in residential care for more than two years, followed by Comprehensive

However, we also consider a short-term funding solution while we implement the long-term vision.

Under this short-term vision, those who need to stay in care homes for more than two years will receive free care after the second year for the remainder of their stay. This will apply from 2014 and will include people who have already been resident in care homes for two years or more on the date of implementation. The costs are expected to be in the range of £0.7 to £0.9 billion in 2014/5. These are our current estimates, which will need to be reviewed.

We have decided to implement this short-term funding solution for the following reasons.

- As the provisions of the Personal Care at Home Bill will help those with highest needs in the community, it seems right that the next step should help those in care homes who also have high needs;
- Care home residents face an especially great risk of catastrophic costs if they have longer than average stays, since care costs in care homes can be around £13,000 per year;
- A person's house is usually taken into account in the means test for residential care but not in the means test for home care, which adds to the risk of substantial use of savings to fund care for those in care homes;
- Those who have been resident for two years or more as self-funders will already have made substantial contributions to the costs of their care.

Note that, this interim stage of reform would be implemented in 2014/15. For the purposes of analysis, we assume that the interim stage of reform would be implemented for two years, with our preferred option of Comprehensive implemented in 2016/17.

Note that when someone moves into a residential home, their costs have two elements: i) the costs of care; and ii) associated charges, such as the cost of utilities and food. These 'accommodation costs' are not covered by the stage two option of free care for anyone in residential care for more than two years, Partnership or Comprehensive. The treatment of accommodation costs under reform are considered later in this section.

*How we will consider Attendance Allowance (AA) and Disability Living Allowance (DLA) (care component)*

Option 5 – Free care for anyone in residential care for more than two years, followed by Comprehensive with possible improvements to the relationship between AA, DLA and social care

The final option considered in the analysis considers the treatment of disability benefits in relation to social care.

As we move forward to the third stage of reform, the Government will ask the Commission as part of their work to examine how we can improve care and support to make it easier for people to access all the support they need and to look at the relationship between AA, DLA and social care. For example, looking at the way in which AA and DLA (care component) are taken into account by local authorities and at ways of giving people more choice about both the care they get and the way they contribute to the National Care Service

We know that currently, many local authorities consider income from AA and other benefits when determining how much state support they provide to an individual. In doing so, they expect individuals to use a proportion of their AA or DLA (care component) to help fund their care.

However we also know that there are significant differences between local authorities around how disability benefits are taken into account when assessing someone's care package, with no consistency between local authorities in whether and how this is done. Some disregard a set amount, some perform complex disability-related expenditure calculations to determine how much to disregard, and some completely disregard all income from disability benefits. We think this can be confusing, and makes the postcode lottery in the current system worse.

As we roll out the National Care Service, which will be a significantly more generous system that will provide support to a greater range of people, we expect that local authorities will continue to take account of the support provided by disability benefits. If local authorities did not take these benefits into account when determining people's care packages, many people would benefit disproportionately from the introduction of a comprehensive National Care Service, and this would be unaffordable for the state.

We want to reduce the postcode lottery of the current system, and ensure greater consistency around the extent to which AA or DLA (care component) is taken into account when determining the size of people's care packages. Therefore we will ask the commission to look at how, under the comprehensive National Care Service, all local authorities could take a more consistent approach to the amount of people's AA or DLA (care component) that is disregarded, to cover remaining disability-related expenditure. This will make the system more affordable for the state.

This would mean that, as is the case with social care now, a proportion of people's Attendance Allowance and Disability Living Allowance (care component) will be consistently seen as a core part of the package provided by the comprehensive National Care Service.

Following the Commission's recommendations, however, we will ensure that there are no cash losers amongst people in the social care system at the time of reform.

***Analysis of costs and benefits***

This analysis considers *projections* of likely costs and benefits; this means that they are based on a series of assumptions about future trends in relevant factors, such as demography, disability and unit costs of services.

They provide indicative costs to compare relative funding options; these costs could alter substantially, following decisions about precisely how the funding models would be implemented and based on overall public spending and prioritisation decisions. A substantial proportion of the costs of any funding option would have to be met from within the public spending envelope set in future spending reviews.

It should be noted that the costs have been estimated on the basis of national average data, and so are unlikely to fully reflect the variation in social, economic and demographic conditions in individual local authority areas.

For the main part, costs and benefits presented in this analysis have been taken from the results of modelling undertaken by the Personal Social Services Research Unit (PSSRU), funded by the Department of Health (Forder, 2009 and Wittenberg, 2008). This modelling has been supported by further analysis undertaken 'off-model' by the Department of Health and other government department analysts.

There is a lack of data on younger adults with care and support needs. Therefore, the same level of analysis that has been undertaken for older people by PSSRU has not been done for younger adults, who would also be a part of the new funding system proposed in the White Paper. We therefore show costs and benefits of older people and younger adults separately to reflect the different methodologies used in estimating costs and benefits.

The costs considered under each of the options are the net costs to the state.

- Additional costs of care to the state: the cost to the state of the social care system is likely to be greater under the alternative funding options considered since they are more generous in the care offer they provide.
- Administration costs: there may be administration costs of implementing and maintaining any new funding system. For example new IT systems or staff training.
- Assessment and care management costs: since more people would be eligible for state funded care, there would be an additional cost in assessing their needs and managing their care.
- Savings to the NHS: there is some evidence that additional money spent (either public or private) on social care activity substitutes for money spent on health care in the NHS.
- Reduction in the costs of Attendance Allowance and Disability Living Allowance (care component): State funded care home residents have their AA or DLA care discontinued after 28 days of stay, under current practice. When more care home residents become state funded, there is, therefore, a cost saving for AA and DLA care.

Note that the costs consider only cash costs. The opportunity cost of the additional spending will depend on how revenue is raised to fund the additional state expenditure; this will be considered by the Commission. The full economic cost is therefore likely to be greater than that considered in this analysis. We would not, however, expect this to change the preferred option. This is why we are clear costs will continue to be refined during implementation and following recommendations.

The benefits considered are the net benefits to the individual.

- Transfer of expenditure from the individual to the state: current expenditure by individuals may be covered by the state under the new funding system, so that individuals could reduce expenditure on care.
- Expenditure on increasing the volume of care activity: some of the additional expenditure on care by the state and individuals (who top-up the state offer) will go towards increasing the volume of care activity provided (whilst some additional state expenditure will replace

individual expenditure – considered above). The benefit to individuals of this additional expenditure is an increase in care received and reduction in unmet need.

- Value of insurance: the availability of (state) insurance against risks provides a welfare gain for individuals and society where individuals are risk-averse.
- Distributional adjustment: we assume that, in general, older people and younger adults with a care need are at the middle or bottom end of the income distribution of society in general. There is therefore a distributional gain from providing more state resource to these people.
- Reduced receipt of Attendance Allowance and Disability Living Allowance (care component): State funded care home residents have their AA or DLA care discontinued after 28 days of stay, under current practice. When more care home residents become state funded, there is, therefore, a loss of AA and DLA care for these people.

The methodology used for estimating all costs and benefits are detailed in Annex B.

### ***Costs and benefits of options considered***

#### Option 1 – Do nothing

##### *Costs*

The costs of doing nothing (i.e. continuing with the current means tested system with implementation of the Personal Care at Home Bill) is therefore assumed to have a zero baseline in line with impact assessment guidance on best practice.

However, we know that the costs of providing care are likely to increase over time, even if there is no policy change, as the population, in general, ages. In this difficult economic climate, we know that local authorities will be challenged to deliver services that meet the needs of their populations, with limited resources in which to do it. However, the funding of the current means-testing system is not considered any further in this Impact Assessment, and will be considered in future spending reviews.

##### *Wider costs to society*

It is also likely that, without reform:

- families will be under pressure to be providing increasing levels of care
- more people may go without care and support
- there is a knock-on impact if people have to give up paid employment to care for their loved ones, affecting the economy and people's ability to save for their own future.

##### *Benefits*

The benefits of status quo are also assumed to have a zero baseline. As with costs, benefits not directly attributable to the policy option under consideration are not incorporated in this analysis.

### **The long-term vision**

#### Option 2 – Partnership as the long-term vision

##### *Costs*

For the purpose of estimating the additional costs of implementing the long-term vision of Partnership or Comprehensive, we assume that implementation would be in 2016/17.

Compared to the 'do nothing' option, net social services expenditure on care is projected to be around £1.5 billion more under the Partnership funding option with a 33 per cent minimum guarantee in 2016/17, rising to £2.0 billion more by 2025/26 (in 2009/10 prices).

We assume that additional state spending on care does, however, lead to two savings to the state: i) savings to the NHS; and ii) cost savings for Attendance Allowance and Disability Living Allowance care.

The former occurs because we assume that there is some substitution between social care spending and health care spending, at the margin. There is evidence, discussed in Annex B, that increases in community-based care for frail older people can lead to savings on hospital services. Note that this is separate from the issue about whether more emphasis on low level preventative services, more integrated working, or other measures might yield efficiency savings to the NHS.

The latter occurs because, under Partnership, more care home residents will become state funded, rather than self-funded. State funded care home residents have their AA/DLAc discontinued after 28 days of stay, under current practice. Since everyone will receive some help towards their care costs under Partnership, regardless of their means, everyone becomes state funded. We therefore assume that care home residents supported by the state lose their entitlement to AA/DLAc. We therefore assume that the cost savings from AA/DLAc are the same as for Comprehensive.

Total costs to the state of Partnership is therefore estimated to be £0.9 billion in 2016/17.

Note that we estimate the increase in cost for assessment and care management from a move to a more universal state funded system below.

**Table 4 Incremental costs to the state of Partnership for older people, 2009/10 prices**

Year	Net public expenditure on care for older people	Costs to the NHS	Costs of AA/DLAc	TOTAL NET COST ON CARE FOR OLDER PEOPLE
	£ billion p.a.	£ billion p.a.	£ billion p.a.	£ billion p.a.
2016/17	1.5	-0.2	-0.3	<b>0.9</b>
2017/18	1.4	-0.2	-0.4	<b>0.8</b>
2018/19	1.5	-0.2	-0.4	<b>0.9</b>
2019/20	1.6	-0.2	-0.4	<b>1.0</b>
2020/21	1.7	-0.2	-0.4	<b>1.0</b>
2021/22	1.7	-0.2	-0.4	<b>1.1</b>
2022/23	1.9	-0.2	-0.5	<b>1.2</b>
2023/24	2.0	-0.2	-0.5	<b>1.3</b>
2024/25	1.9	-0.2	-0.5	<b>1.2</b>
2025/26	2.0	-0.2	-0.6	<b>1.1</b>

Note: Cost estimates may alter slightly depending on the funding arrangement in place prior to implementation. Note also: Cost fluctuations are both a result of the way the micro-simulation model works and due to rounding.

As previously discussed, there is very little data on younger adults with a care need. However, to illustrate the additional costs of the Partnership funding option for younger adults, modelling assumes that, on average, younger adults who do not currently receive state funding would receive an average guarantee rate of approximately 90 per cent in the Partnership model. The additional costs of Partnership for younger adults therefore essentially equates to approximately 90 per cent of the additional cost of Comprehensive.

Note that we assume no cost saving from Disability Living Allowance (care component) from more younger adult care home residents becoming state funded as a result of a move to

Partnership. This is because we assume that there are negligible numbers of younger adults self-funding in care homes under the current system. This means that we assume that a move to Partnership will not bring any care home resident self-funders into the state funded system.

**Table 5 Incremental costs to the state of Partnership for younger adults, 2009/10 prices**

Year	Net public expenditure on care for younger adults	Costs to the NHS	TOTAL NET COST ON CARE FOR YOUNGER ADULTS
	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>
2016/17	0.28	-0.05	0.23
2017/18	0.29	-0.05	0.24
2018/19	0.30	-0.06	0.25
2019/20	0.30	-0.06	0.25
2020/21	0.31	-0.06	0.26
2021/22	0.32	-0.06	0.26
2022/23	0.33	-0.06	0.27
2023/24	0.34	-0.06	0.28
2024/25	0.34	-0.06	0.28
2025/26	0.35	-0.07	0.29

Note: Cost estimates may alter slightly depending on the funding arrangement in place prior to implementation

In addition, there would be administrative costs involved both in setting up, and administering, the Partnership funding option. Since implementation issues of Partnership would be decided in the run up to implementation, we do not estimate the costs here.

However, we do know that moving to an option, like Partnership, is likely to increase the number of people who receive care from the state, thereby increasing the cost of assessment and care management. These costs are twofold:

- more assessments taking place as more people are eligible for state funded care
- more care management costs since more people are eligible for state funded care.

In addition, we might suggest that the means-test taking place under Partnership will be more complicated. Since the details remain unclear, we have not monetised this potential cost in this Impact Assessment.

Estimates for the additional cost of assessment and care management are shown in Table 6.

**Table 6 Additional costs of assessment and care management, 2009/10 prices**

Year	Assessment and care management	
	Younger adults	Older people
	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>
2016/17	0.06	0.36
2017/18	0.06	0.32
2018/19	0.06	0.32
2019/20	0.06	0.35
2020/21	0.06	0.33
2021/22	0.06	0.36
2022/23	0.06	0.36
2023/24	0.07	0.37
2024/25	0.07	0.38
2025/26	0.07	0.40

## Non-monetised costs

PSSRU modelling assumes that unit costs increase in real terms at 1.5 per cent per annum (p.a.) from 2010/11 to 2016/17, and at 2 per cent p.a. in real terms in all other years considered in the analysis (see Annex B). It is assumed that supply would expand to meet demand without any price increase beyond these annual real rises.

## *Benefits*

Table 7 provides an estimate of the benefits for older people of the Partnership funding option. Modelling assumes that total user charges and top-up payments are projected to increase because of the introduction of Partnership (shown by a negative (-) benefit), whilst the cost of the private purchase of care is projected to decrease (shown by the positive (+) benefit). This is because, under Partnership, more people are users of the state system compared to the current means-testing system. Some new entrants to the scheme would have funded their own care before, but under Partnership would pay fees for the part of their care not covered by the state offer. So we see a substitution away from payment for the private purchase of care – i.e. those people not receiving any help from the state – to charges paid into the state-funded scheme to pay for care beyond the guarantee rate. Under the Partnership option people who could afford to do so would also be required to pay their accommodation costs in residential care. Furthermore, wealthier individuals who are new beneficiaries of state funded care may choose to top-up their care offer from the state.

Receipt of AA and DLA (care component) for individuals is also expected to reduce, in line with there being more care home residents being state funded, as opposed to self-funding. See the costs section for further details.

The PSSRU modelling assumes a large increase in demand for social care at the inception of Partnership, as well as a rise in state expenditure. This means that the value of increasing the volume of care activity provided dominates the benefits, since people not only accept the state offer of care, but continue to spend substantial sums of money themselves on complementing or topping up this state offer. Increasing the volume of care activity provided (as opposed to displacing individual expenditure) reduces unmet need and improves user outcomes.

We also estimate i) the value that Partnership offers in terms of reduced risk of substantial costs to service users, i.e. the value of insurance; and ii) the positive impact it has in providing resources to those with incomes below median incomes for the general population.

Note that, for the latter, we assume that older people have, on average, lower incomes compared with the population at large. The value we place on distributional adjustments therefore depends on an individual's *income*. If we are also concerned the individual's *wealth*, then the value we place on this distributional adjustment may be lower. The methodology used to estimate the distributional adjustment factor, and possible alternatives, are discussed at greater length in Annex B. However, note that the distributional adjustment should be seen as illustrative only, and contributes only a small part of the total estimated benefit.

**Table 7 Incremental benefits of Partnership for older people, 2009/10 prices**

Year	Change in user charges	Change in top-up spend	Change in the cost of private purchase of care	Change in AA/DLAc receipt	Additional volume of care activity	Value of insurance	Distributional adjustment	TOTAL NET BENEFIT FOR CARE FOR OLDER PEOPLE
	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>
2016/17	-4.0	-0.4	4.9	-0.3	1.1	0.3	0.1	1.6
2017/18	-4.4	-0.5	4.9	-0.4	1.5	0.3	0.1	1.5
2018/19	-4.4	-0.4	5.2	-0.4	1.1	0.3	0.1	1.5
2019/20	-4.9	-0.4	5.8	-0.4	1.2	0.3	0.1	1.6
2020/21	-5.1	-0.3	6.0	-0.4	1.1	0.3	0.1	1.6
2021/22	-5.4	-0.2	6.3	-0.4	1.1	0.3	0.1	1.7
2022/23	-5.9	-0.3	6.5	-0.5	1.5	0.4	0.1	1.8
2023/24	-6.4	-0.3	7.2	-0.5	1.5	0.4	0.1	2.0
2024/25	-6.8	-0.3	7.7	-0.5	1.2	0.4	0.1	1.8
2025/26	-7.0	-0.3	7.8	-0.6	1.4	0.4	0.1	1.8

Note: Cost estimates may alter slightly depending on the funding arrangement in place prior to implementation

As has been discussed, we have only limited data on younger adults. We therefore assume that the same proportion of the increase in state spending contributes to i) an increase in social care activity; and ii) displacement of individual expenditure, as for older people. Under Partnership, modelling suggests that, on average, around 12 per cent of the increase in state expenditure displaces individual expenditure, with 88 per cent increases social care activity.

**Table 8 Incremental benefits of Partnership for younger adults, 2009/10 prices**

Year	Change in individual expenditure	Additional volume of care activity	Value of insurance	Distributional adjustment	TOTAL NET BENEFIT FOR CARE FOR YOUNGER ADULTS
	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>
2016/17	0.07	0.21	0.06	0.01	0.36
2017/18	0.07	0.22	0.06	0.01	0.37
2018/19	0.08	0.23	0.06	0.02	0.38
2019/20	0.08	0.23	0.06	0.02	0.38
2020/21	0.08	0.24	0.06	0.02	0.39
2021/22	0.08	0.24	0.06	0.02	0.40
2022/23	0.08	0.25	0.07	0.02	0.42
2023/24	0.09	0.26	0.07	0.02	0.43
2024/25	0.09	0.26	0.07	0.02	0.43
2025/26	0.09	0.27	0.07	0.02	0.44

Note: Cost estimates may alter slightly depending on the funding arrangement in place prior to implementation

## Non-monetised benefits

### Improved quality of life for informal carers

Some of the additional state expenditure targeted at care may also complement informal care under the current system. This would not reduce unmet need or reduce private expenditure on care. The benefit in this situation would be an improved quality of life for the carer. However, this benefit is not monetised in this Impact Assessment; this means that the benefits are likely to be an underestimation of the true benefit of the additional state funding for care.

### Improved incentives to save

Overall, the Partnership funding option would be an improvement compared with the current system, by removing the cliff edge means test and introducing a gradual increase in state support. As with the current system, the impact on incentives to save would be mitigated by the means test taking place at the point of need.

## Net benefit

Table 9 and Table 10, below, show the net benefit of the Partnership option for older people and younger adults respectively. Costs and benefits shown in these tables are as shown previously, with costs and benefits discounted at 3.5 per cent per annum from 2009/10. Note that costs include both the cost of care to the state, assumptions around NHS efficiency savings, assumptions around the reduction in the cost of Attendance Allowance and Disability Living Allowance (care component) and estimates for the cost of assessment and care management. Benefits include the change to individual expenditure, the reduction in the receipt of Attendance Allowance and Disability Living Allowance (care component), the increase in social care activity, the value of insurance and the distributional adjustment.

The discounted net benefit of the Partnership funding option for older people is estimated at around £0.2 billion per year over the period to 2025/26. For younger adults, the net benefit is estimated at £0.07–0.08 billion per year over the period to 2025/26.

**Table 9 Incremental net benefit of Partnership for older people, 2009/10 prices (discounted at 3.5% p.a.)**

Year	Discounted costs to the state on care for older people	Discounted benefits for care for older people	Net present value
	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>
2016/17	1.1	1.2	0.2
2017/18	0.9	1.2	0.2
2018/19	0.9	1.1	0.2
2019/20	1.0	1.2	0.2
2020/21	0.9	1.1	0.2
2021/22	1.0	1.1	0.2
2022/23	0.9	1.2	0.2
2023/24	1.0	1.2	0.2
2024/25	0.9	1.1	0.2
2025/26	0.9	1.1	0.2
<b>TOTAL PRESENT VALUE</b>	<b>9.5</b>	<b>11.4</b>	<b>1.9</b>

**Table 10 Incremental net benefit of Partnership for younger adults, 2009/10 prices (discounted at 3.5% p.a.)**

Year	Discounted costs to the state on care for younger adults	Discounted benefits for care for younger adults	Net benefit
	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>
2016/17	0.23	0.29	0.06
2017/18	0.23	0.29	0.06
2018/19	0.22	0.29	0.06
2019/20	0.22	0.28	0.06
2020/21	0.22	0.28	0.07
2021/22	0.22	0.28	0.07
2022/23	0.22	0.29	0.07
2023/24	0.21	0.29	0.07
2024/25	0.21	0.28	0.07
2025/26	0.21	0.28	0.07
<b>TOTAL PRESENT VALUE</b>	2.17	2.84	0.68

Option 3 – Comprehensive as the long-term vision

**Costs**

As for Partnership, we assume that the long-term vision of Comprehensive would be implemented in 2016/17 for the purposes of analysis.

Compared to the ‘do nothing’ option, net public expenditure on care and support is around £3.5 billion more in 2016/17, rising to £5.8 billion in 2025/26.

The savings to the NHS are greater under Comprehensive compared to Partnership, since we assume that state funding leads to a greater increase in social care activity (see the Benefits section).

The cost savings for Attendance Allowance and Disability Living Allowance (care component) are the same for Comprehensive as for Partnership.

**Table 11 Incremental costs to the state of Comprehensive for older people, 2009/10 prices**

Year	Change in net public expenditure on care for older people	Costs to the NHS	Costs of AA/DLAc	TOTAL NET COST ON CARE FOR OLDER PEOPLE
	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>
2016/17	3.5	-0.4	-0.3	2.9
2017/18	3.5	-0.5	-0.3	2.7
2018/19	3.8	-0.5	-0.3	2.9
2019/20	4.1	-0.5	-0.3	3.3
2020/21	4.4	-0.6	-0.3	3.4
2021/22	4.8	-0.7	-0.4	3.8
2022/23	4.9	-0.7	-0.4	3.9
2023/24	5.2	-0.7	-0.4	4.2
2024/25	5.4	-0.8	-0.4	4.4
2025/26	5.8	-0.8	-0.5	4.6

Note: Cost estimates may alter slightly depending on the funding arrangement in place prior to implementation  
 Note also: Cost fluctuations are both a result of the way the micro-simulation model works and due to rounding.

As has been discussed earlier, since modelling of Partnership assumes that, on average, all younger adults receive a 90 per cent guarantee offer, the costs of Comprehensive for younger adults are slightly more than Partnership, in line with what is, essentially, a 100 per cent guarantee offer, i.e. all care free at the point-of-need for those with eligible needs.

**Table 12 Incremental costs to the state of Comprehensive for younger adults, 2009/10 prices**

Year	Net public expenditure on care for younger adults	Costs to the NHS	TOTAL NET COST ON CARE FOR YOUNGER ADULTS
	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>
2016/17	0.32	-0.05	0.27
2017/18	0.33	-0.05	0.28
2018/19	0.34	-0.05	0.29
2019/20	0.34	-0.05	0.29
2020/21	0.35	-0.05	0.29
2021/22	0.36	-0.06	0.30
2022/23	0.37	-0.06	0.31
2023/24	0.38	-0.06	0.32
2024/25	0.38	-0.06	0.32
2025/26	0.39	-0.06	0.33

Note: Cost estimates may alter slightly depending on the funding arrangement in place prior to implementation

In addition, there are administration costs involved both in setting up and administering the Comprehensive funding option. The funding mechanism for Comprehensive will be determined by the Commission, and so the costs of administering the funding mechanism are not monetised in this Impact Assessment.

Both Comprehensive and Partnership represent a move to a universal funding system for social care, in that they both provide people with eligible care needs with help in meeting their care costs. As for Partnership, the costs of assessment and care management for Comprehensive are therefore twofold:

- more assessments taking place as more people are eligible for state funded care
- more care management costs since more people are eligible for state funded care.

Under Comprehensive, there might also be a cost saving since we would no longer assess a person's financial means at the point-of-need. However, this is dependent on the rules around taking Attendance Allowance and Disability Living Allowance (care component) into consideration when determining an individual's care package (considered under Option 5). We are therefore unable to monetise these cost savings in this Impact Assessment.

We assume that the additional cost of assessment and care management for Comprehensive are therefore the same as for Partnership.

#### Non-monetised costs

As for Partnership.

#### Benefits

Table 13 summarises the incremental benefits (over and above the 'do nothing' option) that are projected to accrue as a result of implementing the Comprehensive funding option.

Private expenditure on care reduces under Comprehensive (shown by a positive (+) benefit). However, there are two effects of this reduction in private expenditure: i) user charges rise; and ii) top-up spend rises. The modelling assumes that total user charges increase under the Comprehensive funding option because more people are users of the state system compared to the current means-testing system. Whilst we assume that people face zero charges for care<sup>16</sup>, people in residential care homes will still pay their accommodation costs if they can afford to (see the section on 'Accommodation costs', p.52). This means that wealthier individuals who would previously have been self-funders and paid all care and accommodation costs out-of-pocket would be in the state system and paying accommodation costs as user charges.

Although the state system is more generous under Comprehensive, modelling assumes that top-ups by individuals increase in total. This is because Comprehensive i) brings more people into the state system; and ii) brings wealthier people, who are more able to top-up the state offer, into the system.

The benefit in terms of increasing social care activity is greater under the Comprehensive funding option as compared to the Partnership funding option. This suggests that the reduction in unmet need under Comprehensive is greater, so that individuals' outcomes are more improved.

Since the individual faces zero costs of care under Comprehensive, the value of insurance, or, in other words, the value of certainty, is greater under Comprehensive as compared to Partnership.

We assume that the benefit from distributional adjustment is greater for Comprehensive as compared to Partnership. This is because Comprehensive provides more state funding for older people, who have, on average, lower incomes compared to the population in general. Note, however, that this benefit should be seen as indicative only, since there are other methods for estimating the distributional adjustment factor (considered in Annex B). However, note that the value we place on the benefit from distributional adjustment remains low relative to the other benefits considered under Comprehensive.

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<sup>16</sup> Excluding those people who may want to top-up their care package above that which the local authority assesses meets their needs

**Table 13 Incremental benefits of Comprehensive for older people, 2009/10 prices**

Year	Change in user charges	Change in top-up spend	Change in the cost of private purchase of care	Change in AA/DLAc receipt	Additional volume of care activity	Value of insurance	Distributional adjustment	TOTAL NET BENEFIT FOR CARE FOR OLDER PEOPLE
	£ billion p.a.	£ billion p.a.	£ billion p.a.	£ billion p.a.	£ billion p.a.	£ billion p.a.	£ billion p.a.	£ billion p.a.
2016/17	-2.3	-0.7	4.7	-0.3	1.9	0.7	0.2	4.0
2017/18	-2.5	-0.9	4.6	-0.4	2.3	0.7	0.2	4.0
2018/19	-2.6	-0.9	4.8	-0.4	2.4	0.8	0.2	4.4
2019/20	-2.9	-0.9	5.5	-0.4	2.5	0.8	0.2	4.8
2020/21	-3.1	-0.8	5.8	-0.4	2.6	0.9	0.2	5.0
2021/22	-3.3	-0.9	6.0	-0.4	3.0	1.0	0.2	5.5
2022/23	-3.4	-1.0	6.2	-0.5	3.1	1.0	0.2	5.6
2023/24	-3.7	-1.0	6.8	-0.5	3.2	1.0	0.3	6.0
2024/25	-4.2	-1.2	7.3	-0.5	3.5	1.1	0.3	6.3
2025/26	-4.2	-1.3	7.5	-0.6	3.7	1.2	0.3	6.6

The benefits of the Comprehensive funding option for younger adults are shown below. As with Partnership, we assume that the same proportion of the increase in state spending on Comprehensive contributes to i) an increase in social care activity; and ii) displacement of individual expenditure, as for older people. Under Comprehensive, modelling suggests that, on average, around 27 per cent of the increase in state expenditure displaces individual expenditure, with 63 per cent increasing social care activity.

**Table 14 Incremental benefits of Comprehensive for younger adults, 2009/10 prices**

Year	Change in individual expenditure	Additional volume of care activity	Value of insurance	Distributional adjustment	TOTAL NET BENEFIT FOR CARE FOR YOUNGER ADULTS
	£ billion p.a.	£ billion p.a.	£ billion p.a.	£ billion p.a.	£ billion p.a.
2016/17	0.12	0.20	0.06	0.02	0.27
2017/18	0.12	0.20	0.07	0.02	0.28
2018/19	0.13	0.21	0.07	0.02	0.29
2019/20	0.13	0.21	0.07	0.02	0.29
2020/21	0.13	0.22	0.07	0.02	0.30
2021/22	0.14	0.22	0.07	0.02	0.31
2022/23	0.14	0.23	0.07	0.02	0.32
2023/24	0.15	0.24	0.08	0.02	0.33
2024/25	0.15	0.24	0.08	0.02	0.33
2025/26	0.15	0.24	0.08	0.02	0.34

Note: Cost estimates may alter slightly depending on the funding arrangement in place prior to implementation

### Non-monetised benefits

#### Improved quality of life for informal carers

As with the Partnership funding option, we have not monetised any potential improvement in the quality of life of carers. Since the Comprehensive option offers more care for people, it is likely to further complement informal care.

## Incentives to save

The effect that the Comprehensive option has on incentives to save largely depend on how the additional funding would be raised, as per the recommendations of Commission. We therefore do not discuss here.

## Net benefit

Over the period to 2025/26, the discounted net benefit of the Comprehensive funding option for older people is estimated at £0.6-0.9 billion per year. This is greater than for the Partnership funding option.

**Table 15 Incremental net benefit of Comprehensive for older people, 2009/10 prices (discounted at 3.5% p.a.)**

Year	Discounted costs to the state on care for older people	Discounted benefits for care for older people	Net benefit
	£ billion p.a.	£ billion p.a.	£ billion p.a.
2016/17	2.5	3.2	0.6
2017/18	2.4	3.0	0.7
2018/19	2.5	3.2	0.7
2019/20	2.7	3.4	0.7
2020/21	2.7	3.4	0.7
2021/22	2.9	3.7	0.8
2022/23	2.8	3.6	0.8
2023/24	2.9	3.7	0.8
2024/25	2.9	3.8	0.8
2025/26	2.9	3.8	0.9
<b>TOTAL PRESENT VALUE</b>	<b>27.2</b>	<b>34.8</b>	<b>7.6</b>

The incremental net benefit of Comprehensive for younger adults is shown in the table below.

**Table 16 Incremental net benefit of Comprehensive for younger adults, 2009/10 prices (discounted at 3.5% p.a.)**

Year	Discounted costs to the state on care for younger adults	Discounted benefits for care for younger adults	Net benefit
	£ billion p.a.	£ billion p.a.	£ billion p.a.
2016/17	0.25	0.31	0.06
2017/18	0.25	0.31	0.06
2018/19	0.25	0.31	0.06
2019/20	0.24	0.30	0.05
2020/21	0.24	0.30	0.05
2021/22	0.24	0.30	0.05
2022/23	0.24	0.30	0.05
2023/24	0.24	0.29	0.05
2024/25	0.23	0.28	0.05
2025/26	0.23	0.28	0.05
<b>TOTAL PRESENT VALUE</b>	<b>2.44</b>	<b>2.98</b>	<b>0.55</b>

## *Preferred long-term vision*

We have chosen the Comprehensive option to build the long-term vision because:

- it received the greatest public and stakeholder support

- it has the greatest impact on reducing people's unmet need and therefore the greatest positive impact on outcomes for people
- it will mean that no-one will face catastrophic care costs, and be forced to spend down their assets, to fund their care needs.
- it has the greatest net benefit, since we assume that i) there would be a significant increase in social care activity from the increase in state expenditure; and ii) risk averse individuals would receive positive benefit from the certainty that state provision provides; and iii) it provides the greatest potential saving to the NHS.

The following option considers the impact of introducing an interim option between 2014/15 to 2016/17, as opposed to remaining with the current means-testing system and the implementation of the Personal Care at Home Bill.

### **The short-term vision**

*Option 4 – Free care for anyone in residential care for more than two years, followed by Comprehensive*

#### Costs

In order to estimate the impact of this option, we assume that this interim solution on the way to reaching our long-term vision would be implemented for two years: 2014/15 – 2015/16. Compared to the 'do nothing' option, total net public expenditure on social care is around £0.7 to £0.9 billion more in 2014/15 under the funding option of free care for anyone in residential care for more than two years.

We assume that free care for anyone in residential care for more than two years will entirely displace individual expenditure, and will therefore not lead to an increase in social care activity. This means that we assume that this reform will not lead to any increase in demand for residential care. This is because the significant up-front cost of having to fund two years of a residential care home stay prior to receiving state support, would be a significant deterrent to people who would not otherwise enter care homes deciding to enter residential care in order to benefit from the new policy. Also note that people would still face the costs of accommodation under this funding option – we assume that this would also act as a deterrent against any increase in demand.

We therefore assume that there would be no savings to the NHS from this reform, since it is only when social care activity is increased that they are any potential savings to the NHS (discussed in Annex B).

From 2016/17 onwards, the costs (and benefits) are as for Option 3, implementation of a Comprehensive option as our long-term vision.

See Annex B for details on the methodology for estimating the costs of providing free care for anyone in residential care for more than two years.

**Table 17 Incremental costs to the state of providing free care for anyone in residential care for more than two years (older people), 2009/10 prices**

Year	Change in net public expenditure on care for older people	Costs of AA/DLAc	TOTAL NET COST ON CARE FOR OLDER PEOPLE
	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>
2014/15	0.8 to 1.0	-0.1	0.7 to 0.9
2015/16	0.9 to 1.0	-0.1	0.7 to 0.9

For younger adults, net public expenditure on residential care is expected to be zero, compared to the “do nothing” option. This is because PSSRU modelling assumes that there are negligible numbers of younger adults self-funding in care homes under the current system. This means that changing to a more generous system will not affect costs for younger adults.

There may also be additional administration costs (for example staff training) involved in implementing the interim option. These costs have not been considered here, since they will depend on implementation issues.

We assume that the stage two option of free care for anyone in residential care for more than two years will not increase demand for residential care. However, it will mean that more people are eligible for state funded care in residential care. This has associated costs that are twofold:

- more assessments taking place as more people are eligible for state funded care
- more care management costs since more people are eligible for state funded care.

Modelling suggests that around 50,000 to 65,000 people will benefit from free care for people in residential care for more than two years. The cost of assessment for older people is therefore estimated to rise by around £12–16 million per year. The cost of care management for older people is estimated to rise by around £30–39 million per year.

### Benefits

Table 18 summarises the incremental benefits (over and above the “do nothing” option) that are projected to accrue as a result of implementing the interim option of introducing free care for anyone in residential care for more than two years. Total benefits of this option for older people are estimated at £0.8 to £1 billion in 2014/15.

Note that we do not consider the benefit of increasing social care activity, since, as has been discussed previously, we do not anticipate that this reform will increase demand for residential care.

Furthermore, we do not value any possible distributional adjustment here. Those individuals who are most likely to benefit from this policy are assumed to be relatively wealthy, since beneficiaries of this reform are those who would continue to be self-funding after two years in residential care if it were not for the reform.

There will be some value of insurance benefits under this option. People who value certainty about how much they would need to pay for their care even if they required residential care for several years can purchase impaired life annuities. Providing free care for anyone in residential

care for more than two years will have a similar effect of giving residents certainty about their remaining maximum life-time costs of care.

There could also be some psychological benefits to individuals who are able to avoid selling their home as a result of receipt of public funding of their care after two years. Potential psychological benefits are not included here but are discussed on page 60 in the context of deferrals.

**Table 18 Incremental benefits of providing free care for anyone in residential care for more than two years (older people), 2009/10 prices**

Year	Change in user charges	Change in the cost of private purchase of care	Change in AA/DLAc receipt	Value of insurance	TOTAL NET BENEFIT FOR CARE FOR OLDER PEOPLE
	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>
2014/15	-0.9 to 1.1	1.7 to 2.1	-0.1	0.1 to 0.2	0.8 to 1.0
2015/16	-0.9 to 1.2	1.7 to 2.2	-0.1	0.1 to 0.2	0.8 to 1.1

As with costs, the benefits of this option for younger adults are assumed to be zero.

### Net benefit

Over the period from 2014/15 to 2015/16, the discounted net benefit of providing free care for anyone in residential care for more than two years (for older people) is estimated at £0.2 to 0.3 billion per year.

**Table 19 Incremental net benefit of providing free care for anyone in residential care for more than two years (older people), 2009/10 prices (discounted at 3.5% p.a.)**

Year	Discounted costs to the state on care for older people	Discounted benefits for care for older people	Net benefit
	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>
2014/15	0.5 to 0.7	0.6 to 0.8	0.1
2015/16	0.5 to 0.7	0.6 to 0.8	0.1
<b>TOTAL PRESENT VALUE</b>	<b>1.0 to 1.4</b>	<b>1.2 to 1.6</b>	<b>0.2 to 0.3</b>

### **How we will consider Attendance Allowance and Disability Living Allowance (care component) (AA/DLAc)**

*Option 5: Free care for anyone in residential care for more than two years, followed by Comprehensive with standardised rules around AA/DLAc deduction*

This option considers the costs and benefits of the preferred option for funding the social care system – *Free care for anyone in residential care for more than two years followed by Comprehensive* – with possible improvements to the relationship between AA, DLA and social care.

As we move forward to the third stage of reform, we will ask the Commission as part of their work to examine how we can improve care and support to make it easier for people to access

all the support they need and to look at the relationship between AA, DLA (care component) and social care.

We will ask the Commission to look, for example, at the way in which AA and DLA (care component) are taken into account by local authorities and at ways of giving people more choice about both the care they get and the way they contribute to the National Care Service.

Since the details of the policy will be decided in the run up to implementation, we do not consider costs and benefits in this Impact Assessment. We will, however, quantify the possible costs and benefits once further policy design work has been undertaken and following the commission's recommendations.

### *Risks*

The PSSRU model for older people is a 'state of the art' dynamic microsimulation model and the PSSRU model for younger adults, although an aggregate model, is also thorough and detailed. The PSSRU modelling on which many cost figures are based are therefore careful and detailed.

However, projections of future demand for, and expenditure on, care and support are inevitably sensitive to the assumptions on which they are based. Projections should not be regarded as forecasts: they are based on assumptions about trends in drivers of demand, such as future needs, and are conditional on those assumptions.

The following assumptions are important in the context of longer-term projections.

- Mortality rates in old age are a key factor affecting the projected number of older people requiring care and support. The modelling uses the Government Actuary's Department (GAD) 2006-based principal population projection (GAD, 2007).
- While there are differing views about whether age-specific disability rates in old age can be expected to rise, fall or remain broadly constant in the future, the modelling assumes that age-specific disability rates among older people and younger physically disabled people remain constant over time but rise for younger people with learning disabilities.
- The modelling assumes that the real unit costs of care, such as the cost of an hour's home care, will rise by 1.5 per cent per year to 2016/7 and then by 2 per cent per year.

Sensitivity analyses in earlier PSSRU research have shown that long-term projections of future expenditure on care are highly sensitivity to assumptions about trends in these factors, especially future disability rates and future rises in the real unit costs of care (Wittenberg et al, 2008).

These sensitivity analyses indicate that there is an inevitable degree of uncertainty about the costs of introducing a National Care Service and more especially about the projected costs for the future. A further source of uncertainty arises from assumptions about decisions made in future years by people needing care and their families. The modelling makes assumptions, based on careful analysis, about the numbers of people who do not receive publicly funded care under the current funding system but would seek and be eligible for publicly funded care under the National Care Service.

There is a possibility that the resources required to fund the National Care Service will prove greater than estimated at this stage. To endeavour to mitigate any risk in terms of not meeting future expectations of the National Care Service, modelling of the projected costs of the National Care Service will need to be updated in the future. The Commission will also need to consider carefully the most appropriate and sustainable way for people to make their contribution towards the National Care Service.

Furthermore, the estimated costs of providing free care for anyone in residential care for more than two years need to be treated with some caution. We therefore show a range of estimated costs for this reform. Estimates are sensitive to assumptions on the cross-sectional lengths of stay of care home residents who are privately funded at present. There is very limited data available on these people and their length of stay. There is also some uncertainty about the numbers of care home residents who will benefit from this change in 2014/5 and 2015/6. We expect that some 50,000 to 65,000 care home residents may benefit. Further work will be required on these estimates prior to implementation.

The costs of the proposal will clearly also depend on the care costs that councils will meet for each eligible resident. The modelling assumes that councils will meet similar care costs for this group as for other supported residents. Some of the residents benefitting from this reform, however, are likely to be paying higher care home fees than current supported residents. If councils agreed to fund higher than average care costs for this group, the overall costs of the proposal would be higher. If councils limited their care contributions and in effect provided a fixed amount per resident week, there could be an increase in care home fees met by residents, as seems to have occurred on the implementation of free personal care in Scotland. This would transfer some of the benefits from care home residents to care home providers. Further work is required on this issue to ensure that the additional public expenditure provides value for money.

### *Groups affected*

#### Comprehensive

Under Comprehensive, all adults in England would receive support for their assessed care needs free when they need it, irrespective of their wealth.

Those people benefitting from this reform will be those individuals who, under the current means-testing system, are either i) not eligible for state support based on their financial means; or ii) making means-tested user charges. This means that those benefitting will be concentrated in the wealthier part of the income distribution of older care users.

This does not take into account any recommendations made by the Commission about how contributions will be made to the system. This will be likely to change the distribution of people benefitting from the reform.

#### Free care for anyone in residential care for more than two years

Under free care for anyone in residential care for more than two years, people would only be required to pay for care in residential care for the first two years of their stay in a care home. People benefitting from this reform will therefore be people who would have continued to self-fund after the first two years in residential care, i.e. people who would not have spent down their assets within these first two years.

Possible improvements to the relationship between AA, DLA and social care.

As the Commission to look at how we can improve care and support to make it easier for people to access all the support they need and to look at the relationship between AA, DLA and social care, for example, at the way in which AA and DLA (care component) are taken into account by local authorities and at ways of giving people more choice about both the care they get and the way they contribute to the National Care Service any potential winners and losers resulting from changes are not considered in this Impact Assessment. However, we will

consider the groups affected once further policy design work has been undertaken and depending on the recommendations of the Commission.

### **Summary of funding for adult social care**

The following tables summarise the net present value of benefits for the various options considered for the funding of social care.

**Table 20 Summary of net present value of benefits for the options considered for the funding of social care for older people, 2009/10 prices, discounted at 3.5% p.a.**

Net Present Value of Benefits				
Year	Option 2: Partnership	Option 3: Comprehensive	Option 4: Free care for anyone in residential care for more than two years, followed by Comprehensive	Option 5: Free care for anyone in residential care for more than two years, followed by Comprehensive with standardised rules around AA/DLAc deduction
	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>
2014/15	0	0	0.1	N/A
2015/16	0	0	0.1	N/A
2016/17	0.2	0.6	0.8	N/A
2017/18	0.2	0.7	0.8	N/A
2018/19	0.2	0.7	0.8	N/A
2019/20	0.2	0.7	0.8	N/A
2020/21	0.2	0.7	0.9	N/A
2021/22	0.2	0.8	0.9	N/A
2022/23	0.2	0.8	0.9	N/A
2023/24	0.2	0.8	0.9	N/A
2024/25	0.2	0.8	0.9	N/A
2025/26	0.2	0.9	0.9	N/A
<b>TOTAL PRESENT VALUE</b>	<b>1.9</b>	<b>7.6</b>	<b>0.2-0.3</b>	<b>N/A</b>

**Table 21 Summary of net present value of benefits for the options considered for the funding of social care for younger adults, 2009/10 prices, discounted at 3.5% p.a.**

Net Present Value of Benefits				
Year	Option 2: Partnership	Option 3: Comprehensive	Option 4: Free care for anyone in residential care for more than two years, followed by Comprehensive	Option 5: Free care for anyone in residential care for more than two years, followed by Comprehensive, with AA offset
	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>	<i>£ billion p.a.</i>
2014/15	0	0	0	N/A
2015/16	0	0	0	N/A
2016/17	0.06	0.06	0.07	N/A
2017/18	0.06	0.06	0.07	N/A
2018/19	0.06	0.06	0.07	N/A
2019/20	0.06	0.05	0.06	N/A
2020/21	0.07	0.05	0.06	N/A
2021/22	0.07	0.05	0.06	N/A
2022/23	0.07	0.05	0.06	N/A
2023/24	0.07	0.05	0.05	N/A
2024/25	0.07	0.05	0.05	N/A
2025/26	0.07	0.05	0.05	N/A
<b>TOTAL PRESENT VALUE</b>	<b>0.68</b>	<b>0.55</b>	<b>0.59</b>	<b>N/A</b>

## **A locally-determined funding system**

### ***Current situation and options for reform as considered in the Green Paper***

The existing care and support system is based on a combination of national benefits and local service provision. Local authorities have considerable discretion about the amount of money they spend on social care, through local decisions on eligibility and the amount raised locally through council tax. Many regard the system as unfair and difficult to access due to a lack of transparency, with wide variations in eligibility for services and service provision in different areas of the country.

The Green Paper Impact Assessment considered three options for the future of how the funding system should be determined:

- do nothing and continue with the current system of local determination of eligibility and level of support
- a nationally-consistent system, through a nationally-consistent assessment process and single spectrum of eligibility with local flexibility in local authorities still deciding for themselves the monetary amount of care and support provided at each level of need
- making the allocation of resources standard across England, where the national assessment process would be consistent but this would also result in a nationally-determined level of support.

The national Consultation specifically raised the question of whether respondents felt the system should be determined in a 'fully national' or 'part-national, part-local' way. The findings showed a mixed picture with no clear consensus on the proposed structure. However, many people told us that there should be a level of flexibility in the system so that people have more flexibility over the design and delivery of services based upon local circumstances.

We do not think this can be done with a fully-national system, where the Government would determine how much support people receive, without knowing their individual circumstances.

We, therefore, want to give local authorities the flexibility to deliver innovative solutions that are tailored to local conditions and individual outcomes.

### ***White Paper policy option and objectives***

The White Paper announces that, while a comprehensive National Care Service will have nationally consistent eligibility criteria enshrined in law and will set the point at which someone becomes eligible for state support in England, local authorities will continue to lead delivery of care. Local authorities will be allocated a personal budget to each individual, which will be tailored to each person's needs and circumstances and what they want to achieve.

The White Paper outlines that Government does want to ensure that the support provided by local authorities is suitable, and that it meets people's needs properly. The Care Quality Commission will therefore regularly assess local authorities to ensure that standards of support are being maintained.

## ***Costs and benefits of the White Paper policy option***

### *Costs*

The Comprehensive system is more generous than the care and support currently provided by local authorities. Therefore, introducing the Comprehensive system will create a new burden on local authorities. As shown above, modelling by PSSRU shows that this new burden will be £3.5 billion in the first year. This new burden would need to be fully-funded to avoid increasing pressure on council tax.

Moving from a means-tested to a Comprehensive system is likely to require a new formula for distributing funding to local authorities. Within the calculation of formula grants there are currently two funding formulae for adult social care – one for younger adults and another for older people. These predict the relative need of each council to support people with care and support needs in their area.

The funding formulae may also be very different because they will not take such account of deprivation. In addition to funding the new burden, we may need to take specific account of the distributional effects of introducing radical changes to the adult social care funding formulae. However, it is not possible to assess these effects accurately before the new formulae have been developed.

As the CQC is also responsible for the assessment and regulation of providers of care and support, there are no additional costs and benefits associated with this.

### *Benefits*

The benefits to individuals have not been monetised. The main benefits from a part national, part local funding system are that i) there will be greater national consistency (for example if a person moves area); and ii) each individual would have fully personalised care and support, enabling individuals to get the particular outcomes that they wish to get from their care and support.

### *Risks*

There is a risk that there will be a continuation of the national variability in care packages, including the risk that some councils will continue to offer low personal budgets

We want to ensure that the support provided by local authorities is suitable, and that it meets people's needs properly. The Care Quality Commission's regular assessment of outcomes, services and professionals involved in care and support should ensure that providers meet the requirement to ensure people get appropriate and safe care and support.

### *Groups affected*

This policy is applicable to everyone assessed as having an eligible care and support need.

## **Accommodation costs**

### ***Current situation and options for reform as considered in the Green Paper***

The Government believes that people who need care and support should be encouraged to stay in their own home for as long as they wish, and are able to do so. However, some people will prefer, or may need, to move into residential care – for example, if their needs are increasing, or if they are living on their own.

When someone moves into a residential home, their costs have two elements.

- Firstly, there is the cost of care. Under a comprehensive National Care Service, everyone's assessed care costs in residential care would be met by the state.
- Secondly, there are associated charges, such as the costs of utilities and food. These 'accommodation costs' are not covered by any of the reforms, and we would expect individuals to fund these themselves if they can afford to do so.

We think it is right that accommodation costs are treated differently to care costs, since they include many of the things, such as food and utilities, which people living in their own home are expected to pay for.

Under the policy of providing free care for anyone in residential care for more than two years, and comprehensive, we would expect individuals to pay the costs of accommodation themselves if they could afford to do so.

### ***White Paper policy option and objectives***

Whilst we believe the majority of people should pay for their own accommodation costs in residential care, we think it is unfair that people may have to sell their own homes, when they did not plan to do so, to meet these costs. We therefore consider options around reducing the burden that accommodation costs place on residents of care homes. The policy options considered ensure that no individual is required to sell their home in order to finance their care and support needs in their lifetime, providing significant peace of mind for the person in care.

We propose a number of measures in the White Paper to meet this objective:

- universal deferred payments
- information and advice
- engagement with the private sector
- encouraging more effective use of housing assets.

These measures are considered below.

### **Universal deferred payments**

The White Paper outlines that Government will introduce a universal deferred payment mechanism for accommodation costs in residential care under the comprehensive National Care Service. This means that those eligible can charge their accommodation costs to their estates when they die.

A deferred payment agreement is a loan, provided by the local authority, which covers the costs of accommodation in residential care. The loan is set against the home of someone who has gone in to residential care. It is available only to those people who would not be able to afford the residential care charges without selling their home. This means that people in residential care are only eligible for a deferred payment agreement if they could not meet accommodation

costs without using the value of their home or reducing their non-saving assets below £23,000 (as under the current eligibility criteria for deferred payments).

Under a deferred payment agreement, the local authority pays the accommodation costs of residential care, and places the charge on the person's home. When the person dies, the debt is repaid from that person's estate.

A deferral may give a family more options about how to pay a charge which has accrued. For example, the debt may be small enough that re-mortgaging the house or a loan may cover the debt and the house need not be sold. Obviously, in some occasions, the home would need to be sold in order to repay the loan. However, in this case, a deferred payment would protect people from having to sell their homes in their lifetimes – therefore providing significant peace of mind for the person in care.

Many local authorities already offer deferred payments, but it is not universal across England. Under the current funding system, local authorities have discretionary powers, under section 55 of the Health and Social Care Act 2001, to agree a deferred payment agreement with someone entering residential care. National guidance suggests that an individual should be eligible for entering in to a deferred payment agreement if:

- the client is entering a care home on a permanent basis; *and*
- the value of the client's home is not disregarded in the means-test for state contribution to social care costs; *and*
- the client does not have enough income and/or capital, other than the value of their main or only home, to meet the cost of their accommodation and/or care; *and*
- the client either:
  - for whatever reason, does not wish to sell their home; or
  - the client is unable to sell their home quickly enough to pay for the care home fees.

We are not proposing a change to these eligibility criteria in the White Paper.

The rules governing the operation of deferred payments (including the eligibility criteria set out above) are set out in guidance to local authorities, rather than Directions. The guidance states that Ministers expect local authorities to offer deferred payment agreements where appropriate, though local authorities do have discretion in individual cases:

*“Whilst councils have discretion to decide on a case by case basis, whether to enter into a deferred payments agreement, it is the Department's view that if a local authority were to have a policy of never exercising its discretionary powers to make deferrals, it is likely the courts would find this to be unlawful.”<sup>17</sup>*

Many local authorities already offer deferred payments, but it is not universal across England. We are therefore going to require local authorities to provide accessible deferred payment agreements to everyone who cannot afford to pay their accommodation costs without using up the last of their savings and selling their home. Not everyone who is in residential care will be eligible for a deferred payment. We envisage that deferred payments will continue to be offered on this same basis as under the current system (as described) will continue.

The costs and benefits of this measure are considered below.

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<sup>17</sup> Local Authority Circular, LAC (DH) (2009) 3, 25 March 2009.

## Information and Advice

The White Paper outlines the importance of providing people with information that will help them to manage their finances effectively so that they can protect more of their assets, should they become liable for accommodation charges in residential care. This would be in addition to the universal deferred payment mechanism offered to ensure that people are getting appropriate information and advice to enable them to make timely decisions.

The White Paper outlines that guidance and information may need to be available on:

- the range of products and services available to mitigate the risk of catastrophic accommodation costs
- financial planning for retirement, working at the national level with other government departments such as DWP
- the range of voluntary sector organisations positioned to provide independent advice.

Any advice and guidance would be delivered through similar channels to those outlined in the earlier section on information and advice from this Impact Assessment.

### *Costs and benefits*

As information and advice linked to accommodation costs would be delivered through similar mechanisms to other information and advice around the National Care Service and so would need to be considered as part of the content of the national portal. A discussion around costs and benefits of this are included earlier in this Impact Assessment (see pages 20–21).

## Engagement with Private Sector

Existing commercial financial products are not suitable for everyone; in the case of long-term care insurance products, premiums can be high and unaffordable for some.

The White Paper outlines that Government will ask the National Care Service Leadership Group to engage with the insurance industry to identify opportunities for innovative and more affordable products to cover accommodation costs at implementation of the fully comprehensive National Care Service; and we will ask the National Care Service Leadership Group to identify and, where appropriate, remove barriers that might prevent these services working effectively.

### *Costs and benefits*

Since the details of any further policy recommendations are subject to engagement with the private sector, costs and benefits cannot be detailed in this Impact Assessment.

## Encouraging more effective use of housing assets

Individuals in residential care might avoid accruing charges against their estate by letting the house they have vacated to cover accommodation charges.

The White Paper outlines that Government will ask the National Care Service Leadership Group to engage with the property services sector, the Local Government Association and voluntary organisations to identify and evaluate potential options for rental schemes that could allow people to generate an income from vacated properties; and then to develop any promising ideas that could cover or contribute to their accommodation costs

## *Costs and benefits*

Since the details of any further policy recommendations are subject to engagement with the private sector, voluntary organisations, and the Local Government Association, costs and benefits cannot be detailed in this Impact Assessment.

### ***Costs and benefits of White Paper policy option***

As has been described, the costs of offering information and advice on deferred payments is assumed to be incorporated into the wider policy of increasing information and advice. Furthermore, since the details of any further policy recommendations are subject to engagement with the private sector, costs and benefits of these further options are not detailed in this Impact Assessment.

This section therefore considers the costs of making deferred payments universal, compared to a 'do nothing' option.

#### Option 1 – do nothing

##### *Costs*

The costs of doing nothing (i.e. continuing with the current system of giving local authorities discretion over offering deferred payments) is assumed to have a zero baseline. This means that we assume that all deferred payment agreements that have already been agreed, and that would have been agreed to under current policy, by local authorities and residents in their areas have been funded. Only the costs of any additional deferred payment agreements that are agreed to *as a direct result of a change in policy* are considered under option 2. This is in line with Impact Assessment guidance on best practice.

##### *Benefits*

Similarly, the benefits of status quo are assumed to have a zero baseline.

#### Option 2 – Local authorities are required to offer deferred payment agreements to all those eligible

##### *Costs*

Since deferred payments are loans to the individual, over an infinite time horizon the cash cost to local authorities of offering deferred payments is likely to be zero, because they will receive all of the money paid out via a loan back when individuals pay off the loans. Over an infinite time horizon, the only cost to the local authority is the opportunity cost of providing a loan at a zero real interest rate (as proposed under the deferred payment agreements) rather than receiving the market interest rate from investing the money elsewhere. Note, however, that there may be some small cost to the local authority of people defaulting on the loans.

However, over a finite time horizon (assumed to be 20 years in this analysis) there is a net cost to the local authority. In the initial years of the policy, this cost is incurred because the local authority is required to pay out under the deferred loan agreements whilst only a minority of people are paying off the loans. As time goes on and people continue to pay off loans, the local authority can use this revenue to make further loans.

However, the revenue from people paying off loans is unlikely to fully cover the cost of new loans being paid out because:

- the cost of accommodation in residential care homes is rising so that people paying off loans for a care home place in previous years will not cover the cost of a residential care home place in the present

- the number of people aged 75+ is rising so that those people paying off previous loans will be fewer in number than those demanding loans in the present. However, this effect may be reduced with the development of other housing with care approaches substituting for residential care and more people being cared for in their own home.

Under Option 2, central government would provide local authorities with the means to start making deferred payments while they were not receiving enough revenue to make the system self-funding. For the purpose of analysis for the impact of making deferred payments universal, we assume that the policy would be implemented in 2016/17.

Note that funding for the on-going costs of deferred payments (due to demographic and unit cost pressures) will be subject to future spending reviews.

The methodology for estimating the initial grant requirement is outlined as follows.

For the purpose of analysis, we also assume that, a comprehensive National Care Service is implemented in 2016/17 for all adults in England with an eligible care need, free when they need it. Under this system, people in a care home would only be liable for their accommodation costs.

We estimate that there are currently around 45,000 privately financed admissions to residential care homes per year. We assume that a proportion of these privately financed residents would have taken up deferred payments in local authorities already offering deferred payments, without implementing our proposal to make deferred payments universal. We assume that these agreements are already funded (e.g. by revenues received from other people paying off other deferred payment loans, previous grant provided, etc). We assume a reasonable *additional* uptake of deferred payment agreements as a direct result of this policy is around 2,500 in 2016/17 (i.e. implementation). The limited data available suggests that this is a reasonable assumption.

We also assume that the number of deferred payments agreed to as a result of this policy rises at 2.5 per cent p.a., in line with the rise in the number of people aged 75+.

We take estimates for the weekly cost of residential care and accommodation costs over the period 2016/17–2025/26 from the PSSRU discussion paper by Forder and Fernandez, *Analysing the costs and benefits of social care funding arrangements in England: technical report 2009*, shown in Table 22. Post-2026, we assume that the unit costs of care homes rise at 2 per cent per annum, in real terms, in line with the general trend over the period 2016/17–2025/26.

**Table 22 Care home charge and accommodation charge p.a., 2006/07 prices**

Year	Care home charge	Accommodation charge
	£ per week	£ per week
2016/17	574	306
2017/18	586	312
2018/19	597	319
2019/20	609	325
2020/21	621	332
2021/22	634	338
2022/23	647	345
2023/24	659	352
2024/25	673	359
2025/26	686	366

Source: Forder and Fernandez, *Analysing the costs and benefits of social care funding arrangements in England: technical report 2009*

We assume that individuals will be able to contribute their Pension Credit minus the personal allowance towards the costs of accommodation<sup>18</sup>. In reality, some individuals will be able to contribute more than this, and so would be eligible for borrowing less money under a deferred payment agreement. The costs we present may therefore be an overestimation.

In line with this assumption, estimates for how much an individual might borrow per year to meet the costs that they face for residential care are shown in Table 23.

**Table 23 Estimate of the maximum annual amount that individuals might borrow under a deferred payment agreement<sup>19</sup>, 2006/07 prices**

Year	Maximum annual amount that individuals might borrow
<i>£ p.a.</i>	
2016/17	10,771
2017/18	11,089
2018/19	11,416
2019/20	11,744
2020/21	12,082
2021/22	12,425
2022/23	12,779
2023/24	13,137
2024/25	13,501
2025/26	13,876
2026/27	14,256
2027/28	14,645
2028/29	15,041
2029/30	15,445
2030/31	15,857
2031/32	16,277

In addition, we assume that administration costs to the local authority are around £320 per deferred payment agreement, and that these would be paid by the individual taking out the deferred payment agreement with the local authority – administration costs are therefore not included in the grant required from central government. Administration costs are considered in the ‘Benefit’ section since they fall to the individual.

The net cost to the local authority (i.e. estimated grant required from central government) is the cost of outlays to pay for new and existing deferred payment agreements minus revenues received from individuals paying off deferred payment agreement loans. We assume that 50 per cent of individuals will repay the loan within three years of them initially taking out the loan (in line with average stays in residential care homes). We assume that the last cohort of people will pay off their loan 10 years after first taking out the loan. Clearly, there will be some loans that are outstanding after 10 years; we assume that all people pay off their loan within 10 years to simplify calculations<sup>20</sup>. Note that, within these estimates, we assume that the repayment is delayed by one year after the individual leaving residential care.

Table 24 shows the grant required from central government (i.e. difference between outlays for deferred payment agreements and revenues received from individuals paying off the loan) over the period 2016/17 to 2031/32.

<sup>18</sup> Note that, for younger adults with a care need, their incomes might be different.

<sup>19</sup> This includes the annual cost of accommodation minus annual earnings from pension credit plus the personal allowance. This is considered the maximum amount that a person may borrow under a deferred payment agreement because they may also have other income that the local authority would expect them to use towards paying their accommodation costs.

<sup>20</sup> Note that younger adults taking out deferred payments may stay in residential care far longer than 10 years.

Furthermore, we assume that a nominal rate of interest will be charged on the loans under deferred payment agreements, so that individuals are repaying the *real* value of the loan they received. This is different from current practice, where zero nominal interest is charged on loans. This means that local authorities will also be able to charge a nominal rate of interest on all new deferred payment agreements that we assume would be made under the current practice after the implementation date of the reforms. We therefore assume that there would be a notional cost saving to the local authority as compared to the 'do nothing' option, shown in Table 24.

However, since individuals will pay only a nominal rate of interest on the loans, there is an opportunity cost of local authorities using this grant to issue deferred payments. This opportunity cost is also shown in Table 24.

**Table 24 Net costs of deferred payment agreements, 2009/10 prices**

Year	Required grant from central government	Cost saving from interest received on all deferred payments not as a result of the policy	Opportunity cost of zero real interest on deferred payment agreements
	£ million p.a.	£ million p.a.	£ million p.a.
2016/17	28.4	-1.3	1.1
2017/18	37.8	-2.2	1.9
2018/19	45.7	-2.9	2.6
2019/20	48.8	-3.6	3.2
2020/21	53.9	-4.2	3.8
2021/22	55.6	-4.8	4.3
2022/23	53.7	-5.3	4.8
2023/24	47.7	-5.8	5.2
2024/25	37.2	-6.2	5.5
2025/26	22.0	-6.5	5.8
2026/27	23.1	-6.9	6.1
2027/28	24.2	-7.2	6.5
2028/29	25.4	-7.6	6.8
2029/30	26.6	-8.0	7.2
2030/31	27.9	-8.4	7.5
2031/32	29.3	-8.9	7.9
<b>TOTAL</b>	<b>587.5</b>	<b>-89.6</b>	<b>80.3</b>

### Benefits

The deferring of costs is essentially a low cost loan to cover the costs of a residential care home stay until a time that is more convenient for the individual. The benefits of deferred payments to users (and their heirs) are measured as:

- the psychological benefits of not having to sell their home in their life-time; *plus*
- the difference between market and zero real interest rates on outstanding loans; *minus*
- administration costs.

We have not included the possible revenues earned by individuals who would be able to rent out their former home under a deferred payment, since *under present arrangements*:

- if the house could not be sold, the user could let the house for rental income; or
- if the house was sold, the user could place the revenues from the sale on deposit and earn a revenue similar to the rental income if the house was not sold.

These benefits are therefore not specific to the policy options considered.

Table 25, below, shows the net benefit (to the user/heir) of deferred payments. This includes:

- *Illustrative psychological benefits.* We cannot, in any definitive way, value the psychological benefit of deferred payments. This is partly because while we assume that there are significant potential benefits of the policy, the assumptions required to monetise these are plausible but not evidenced. Nevertheless, it is possible to make some assumptions to derive some figures to illustrate the possible benefit. We begin by making the simplifying assumption that all individuals who would require a deferred payment under this new universal scheme would do so because they felt that it reduced their anxiety when entering a residential care home<sup>21</sup>. We therefore assume that people entering in to a deferred payment agreement experience some sort of Quality-Adjusted Life Year (QALY) gain. This allows us to come up with a monetised benefit. We assume that the increased benefit would be represented by a move from “moderate” to “mild” anxiety score on the EQ-5D survey, which translates to a QALY improvement of 0.071<sup>22</sup>. With a QALY valuation of £50,000, this would give an expected monetised benefit of £3,350 per recipient per year. We then use the survival figures used for estimating the costs of deferred payments to approximate how many years each recipient would benefit.
- *The difference between market and zero real interest rates on outstanding loans.* We assume that a real interest rate of around 4 per cent per annum (i.e. after inflation) would operate on loans taken out in the private sector. We therefore estimate that an individual entering into a deferred payment agreement will save around 4 per cent of the value of the loan they take out with the local authority per annum. Note that this benefit to the individual is the inverse of the cost to local authorities of offering a zero real interest rate on loans.
- *Administration costs.* All administration costs faced by councils will be passed onto the individual under reforms proposed in the White Paper. We assume that administration costs to each individual entering into a deferred payment is around £320 (in 2009/10 prices).

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<sup>21</sup> Clearly, some people will need to defer the costs of care/accommodation that they face due to a delay in the sale of their home; in these cases, a deferred payment is a necessity and may not, therefore, have psychological benefits for the individual. For these people, we assume that the local authority would already be deferring the costs that they face until the time when their home is sold. These people are therefore not considered under the proposals here since they would be captured in status quo.

<sup>22</sup> This assumes that an individual entering into a deferred payment agreement scores a 2 on each aspect of the EQ-5D, with an improvement from 2 to 1 on the anxiety measure. This equivalent to a move from a QALY value at 0.587 to 0.516.

**Table 25 Benefits of deferred payment agreements, 2009/10 prices**

Year	Illustrative psychological benefits	Difference between market and zero real interest	Administration costs	TOTAL BENEFIT
	<i>£ million p.a.</i>	<i>£ million p.a.</i>	<i>£ million p.a.</i>	<i>£ million p.a.</i>
2016/17	3.1	1.1	- 0.7	3.4
2017/18	5.6	1.8	- 0.8	6.7
2018/19	8.8	2.5	- 0.8	10.5
2019/20	11.0	3.0	- 0.8	13.2
2020/21	13.8	3.5	- 0.8	16.5
2021/22	17.1	4.0	- 0.8	20.3
2022/23	21.0	4.5	- 0.9	24.6
2023/24	25.5	4.9	- 0.9	29.5
2024/25	30.7	5.2	- 0.9	35.0
2025/26	31.4	5.5	- 0.9	36.0
2026/27	32.2	5.8	- 1.0	37.1
2027/28	33.0	6.1	- 1.0	38.2
2028/29	33.9	6.4	- 1.0	39.3
2029/30	30.5	6.8	- 1.0	36.2
2030/31	27.8	7.1	- 1.1	33.8
2031/32	24.4	7.5	- 1.1	30.8
<b>TOTAL</b>	<b>349.8</b>	<b>75.7</b>	<b>- 14.4</b>	<b>411.0</b>

### Net benefit

Table 26 shows the discounted net benefit of deferred payments. Over a 20-year period, the net benefit is significantly negative, so that the estimated costs of deferred payments are far higher than the illustrative benefits. However, in later years, when the net cost of the scheme is lower since revenue is received from people paying off the loans, the net benefit is positive.

Over an infinite time horizon, the benefits of deferred payment would be at least equal to the costs, because:

- the opportunity cost to the local authority of offering loans at zero real interest rate would be equal to the benefit to the individual of receiving a loan at zero real interest
- the psychological benefit to the individual would be at least as great as the administration cost that they faced; otherwise, they would have no incentive to enter in to the loan.

**Table 26 Incremental net benefit of deferred payment agreements, 2009/10 prices (discounted at 3.5% p.a.)**

Year	Discounted net costs	Discounted benefits	Net benefit
	£ million p.a.	£ million p.a.	£ million p.a.
2016/17	22.2	2.8	-19.4
2017/18	28.6	5.4	-23.2
2018/19	33.3	8.2	-25.2
2019/20	34.4	9.9	-24.4
2020/21	36.6	12.0	-24.6
2021/22	36.5	14.3	-22.2
2022/23	34.0	16.7	-17.3
2023/24	29.1	19.4	-9.7
2024/25	21.9	22.2	0.3
2025/26	12.3	22.0	9.8
2026/27	12.4	21.9	9.5
2027/28	12.6	21.8	9.2
2028/29	12.8	21.7	8.9
2029/30	13.0	19.3	6.3
2030/31	13.1	17.4	4.3
2031/32	13.3	15.3	2.0
<b>TOTAL PRESENT</b>	<b>366.1</b>	<b>250.3</b>	<b>-115.8</b>

### Risks

There are some risks around the estimation of the cost of deferred payments, including those below:

- Uptake of deferred payments as a result of making universal payments universal may be greater than we estimate. However, we argue that our estimate is the best estimate, given limited available data. Our estimates for the cost of deferred payments may, therefore, be an underestimate or overestimate, depending on demand.
- The size of the loan under deferred payments. Under the system of deferred payments, people are only able to defer the costs that they cannot meet from their incomes. We assume that everyone would be able to contribute his or her Pension Credit minus Personal Allowance, as the minimum amount of income that any individual would have. In reality, care home residents deferring the costs of accommodation may have higher incomes than this amount. We might therefore have overestimated the loans made under deferred payments.
- There is little evidence on how long people stay in residential care. Estimates of the grant required from central government to fund deferred payments are reliant on assumptions made, and therefore there is some uncertainty.
- We do not estimate the cost as a result of people defaulting on loans made under the deferred payment scheme. Note that we envisage that defaults are unlikely to occur. However, this may add further cost to the scheme.
- We assume that demand for deferred payments will rise in line with projections of the number of people aged 75+. However, with the development of other housing with care approaches, this may not be the case. We may, therefore, be overestimating the cost of deferred payments in future years.
- The costs of making deferred payment agreements universal will clearly also depend on the accommodation costs that councils will meet for each eligible resident.

### ***Groups affected***

The group benefitting from deferred payments will be home-owners with property they do not want to sell and with modest liquid wealth and incomes.

## Specific Impact Tests: Checklist

Type of testing undertaken	<i>Results in Evidence Base?</i>	<i>Results annexed?</i>
<b>Competition Assessment</b>	<b>No</b>	<b>Yes</b>
<b>Small Firms Impact Test</b>	<b>No</b>	<b>Yes</b>
<b>Legal Aid</b>	<b>No</b>	<b>Yes</b>
<b>Sustainable Development</b>	<b>No</b>	<b>Yes</b>
<b>Carbon Assessment</b>	<b>No</b>	<b>Yes</b>
<b>Other Environment</b>	<b>No</b>	<b>Yes</b>
<b>Health Impact Assessment</b>	<b>Yes</b>	<b>No</b>
<b>Race Equality</b>	<b>Published separately – See Annex A for link</b>	
<b>Disability Equality</b>		
<b>Gender Equality</b>		
<b>Human Rights</b>		
<b>Rural Proofing</b>		

## Annex A – details of additional assessments

### Competition assessment

As outlined earlier in this Impact Assessment, as we move towards implementation of reform proposals and recommendations on key aspects of the system are received (including from the National Care Service Leadership Group and the Commission), it will be necessary to do further work to consider the implementation impact on competition.

#### **1) In any affected market, would the proposal directly limit the number or range of suppliers?**

We do not anticipate direct impacts on the number or range of suppliers of care and support services from any of the proposals.

#### **2) In any affected market, would the proposal indirectly limit the number or range of suppliers?**

We do not anticipate that proposals will indirectly limit the number or range of suppliers. In fact, under the National Care Service, it will be increasingly important for local authorities to understand the needs of their own communities, developing a diverse and healthy local care market as they look to encourage and support a wide and diverse range of high quality services for their populations. We hope that the proposals taken forward to build the National Care Service, including as part of ongoing transformation should promote competition, encouraging local authorities to develop the local market and ensure there is choice for individuals.

#### **3) In any affected market, would the proposal limit the ability of suppliers to compete?**

We do not anticipate that the proposals will limit the ability of providers of care services to compete effectively.

There may be an impact on the providers of long-term care insurance, impaired life annuities and similar financial products for long-term care needs. It is possible that, in a comprehensive National Care Service for all adults in England with an eligible care need, free when they need it, the incentive to buy insurance would be more limited. Insurance could still be sought to cover accommodation costs in care homes rather than care costs. Such more limited policies would be expected to have lower premiums. This may have some impact on the insurance market in terms of changes in demand for financial products. However, it is not possible to quantify the impact on competition until recommendations on contributing to the National Care Service is determined by the Commission.

#### **4) In any affected market, would the proposal reduce suppliers' incentives to compete vigorously?**

Overall it is likely that the proposals set out would serve to stimulate and encourage competition in terms of activities being considered around market development and encouraging local authorities to consider how they can support the right mix of services that enable people to have control and choice in their local areas.

### Small firms impact test

The White Paper announces that a regional demonstrator site will be set up as the basis for a licensing scheme for social care workers and healthcare support workers. The scheme will be in

partnership with unions, workers and those who use services. It is hoped that employers who invest in training will also be recognised through the programme, for example through a kitemark as Investors in Care. Evaluation of the demonstration site will need to work out how best to balance the burden on small businesses with the need to safeguard those receiving care services and the opportunities that a kitemark scheme offer for businesses.

### **Legal aid**

It is not anticipated that any proposals in the Care and Support White Paper will impact on legal aid.

### **Sustainable development**

The White Paper does not outline proposals that would directly impact on NHS or local government estates. However, the aim of creating a National Care Service fit for future generations, that supports people to have access to the care and support they need, wherever they live, is funded in a fiscally-responsible way and has services that are built on the premise of high quality care is linked with the key principles of sustainable development, namely:

- ensuring a strong, healthy and just society
- achieving a sustainable economy
- promoting good governance.

### **Carbon assessment and other environment**

It is not anticipated that any proposals in the Care and Support White Paper would impact on these areas.

### **Equality Impact Assessment**

The specific impact of the final proposals on key equality strands – age, gender, disability, sexual orientation, faith/belief, race – are considered more fully in a separate Equality Impact Assessment, that also considers the proposals in light of key human rights elements, available via <http://careandsupport.direct.gov.uk> .

## Annex B: technical annex for Fair Funding

### Introduction

The figures in the Impact Assessment considers *projections* of likely costs and benefits; this means that they are based on a series of assumptions about future trends in relevant factors, such as demography, disability and unit costs of services. They provide indicative costs to compare relative funding options; these costs could alter substantially following decisions about precisely how the funding models would be implemented and based on overall public spending and prioritisation decisions. A substantial proportion of the costs of any funding option would have to be met from within the public spending envelope set for future spending reviews. It should be noted that the costs have been estimated on the basis of national average data, and so are unlikely to fully reflect the variation in social, economic and demographic conditions in individual local authority areas.

For the main part, costs and benefits presented in this analysis have been taken from the results of modelling undertaken by the Personal Social Services Research Unit (PSSRU), supported by further analysis undertaken “off-model” by DH and other Government Department analysts.

### Older People

PSSRU have used their dynamic micro-simulation model (DMS) to analyse the effects of the funding options considered for older people. The model takes the actual individuals that were sampled in the British Household Panel Survey (BHPS) and, based on their reported characteristics, simulates how their wealth, levels of need, rates of disability, health, housing tenure, household composition, socio-economic characteristics, and so on will change in the future. By embodying a range of behavioural rules – again based on analysis of the BHPS and a range of other data sets – the model can project how a change in the social care and benefits system would affect people. The sample population is followed through time, with their characteristics updated in order to see how, for example, their use of services would change, how they might have to spend-down their wealth to pay for care, how their entitlement to benefits might change and so on.

The following box summarises some of the underlying assumptions of the model used to determine the impact of different funding options considered for older people. For further details of the assumptions incorporated into the model, see Julien Forder, José-Luis Fernández, *Analysing the costs and benefits of social care funding arrangements in England: technical report 2009*, PSSRU Discussion Paper 2644 (available at <http://www.pssru.ac.uk/> ).

### **BOX 1: Key assumptions of the model for older people:**

- The analysis is carried out using a dynamic micro simulation model, described in Forder and Fernandez 2009.
- To model care packages, the PSSRU model assumes that the current assessment framework, and therefore the care offer under the current means-testing system, will continue in the future. This means that after an assessment, people with the same level of need will be offered by the public system the same level of care in the future as they would now. At present, in order to determine whether a person should be offered support, local authorities use a needs-based eligibility test in order to decide access to public support. People are assessed according to the *Fair Access to Care* (FACS) framework, which allows care managers to assess the level of need of applicants into four FACS bands: low, moderate, substantial and critical. The PSSRU model replicates this process, and defines needs thresholds compatible with national observed levels of service take up published in Referrals, Assessment and Packages of Care (RAP) returns. In particular, whether a person is offered public support (and the amount of care offered) is assumed to depend on a person's ability to perform activities of daily living (ADLs), their level of informal care support, their age and gender. The relationship between need and the public service offer is assumed to remain constant through time. Whether or not people *accept* the offer depends on the charges imposed by different funding systems and the individual's assumed willingness to pay for the services.
- The state offer of support defines the *normative* package of care, equivalent to the base amount that is deemed to be required for someone given their assessed needs. The normative package attempts to replicate current average national allocation patterns of assessment and support. People with needs below the national average needs-eligibility threshold have a normative package of zero. This normative package of care varies with a person's need and access to informal care. The following table shows the value of the national average weekly normative package of care, by the activities of daily living need, access to informal care and age (where age is used as a proxy for aspects of disability that are not captured by ADLs).

#### **Average normative care packages among care recipients (£/week in 2006 prices, including hotel costs) by disability level, age and informal support**

ADL need	Informal care		No informal care	
	Less than 85	Over 85	Less than 85	Over 85
1	50	55	85	88
2	59	65	99	102
3	72	77	116	117
4	98	103	152	153
5	138	142	209	210

*Source:* Forder and Fernandez (2009) "Analysing the costs and benefits of social care funding arrangements in England: technical report" PSSRU Discussion Paper 2644, page 21

Under all funding options, only state expenditure on a normative package of care is considered in the figures reported in the Impact Assessment. In all funding options considered, anyone who wants to exceed this normative package will pay the full cost of the additional amount themselves.

- Age and sex-specific rates of disability will remain unchanged in the future, so that with an ageing population (using the Government Actuary Department (GAD) central projections), there is a projected rise in the total numbers of people with disability in the future (by an equivalent of around 2 per cent per annum).

### ***Key assumptions of the model for older people (continued...):***

- Unit costs increase in real terms at 1.5 per cent p.a. from 2010/11 to 2016/17, and at 2 per cent p.a. in real terms in all other years considered in the analysis.
- In 2011/12, modelling assumes that there will be free personal care in the home for all individuals with high levels of need, regardless of their wealth. Free personal care in the home is modelled as part of the base case alongside the means-testing system. Comprehensive and Partnership (with free personal care in the home for those with critical care needs continuing) are compared to this base case. Modelling assumes that all people with critical needs (as defined by the FACS framework) would be entitled to free personal care in the home, with personal care assumed to contribute to around 70 per cent of the total cost of the normative package of care. The net effect of these assumptions on the cost of implementing the Personal Care at Home Bill are that they are in line with those presented in the Personal Care at Home Impact Assessment. In the model, demand effects operate so that people's behaviour changes according to the charge they face. Where the costs of care are reduced to zero, we would therefore see higher recipient numbers, other things equal. There is also the prospect that some people will delay entry into a care home and this too would lead to an increase in the number of people eligible for free personal care. These effects would increase free personal care costs above those estimated just on the basis of price effects.
- Free care for anyone in residential care for more than two years is assumed to be implemented in 2014/15, a comprehensive National Care Service is implemented in 2016/17.
- Modelling assumes that state entitlement to care remains 'carer-sighted', i.e. dependent on a person's access to informal care. Informal care is modelled principally on whether individuals live alone, based on evidence from the British Household Panel Survey. Informal care by people living outside the home was imputed using data from the English Longitudinal Study of Ageing. This means that the availability of informal care is exogenous and so independent of the funding option considered.

### Free care for anyone in residential care for more than two years (for older people only)

Modelling for the stage two option of providing free care for anyone in residential care for more than two years has been undertaken by Department of Health analysts. The method we use to estimate the costs of this policy is as follows:

- take the estimated number of self-funders in care homes in England
- apply to it the estimated proportion of these residents who on a given day have been resident in a care for 2 years or more, to obtain an estimate of the number of beneficiaries
- apply to this the estimated annual unit cost of care in a care home, minus the accommodation costs, to obtain the estimated total cost of the model to social services
- estimate the savings in AA/DLAc that can be expected when the residents concerned become publicly funded.

Note that we assume that the costs for those currently charged for residential care are negligible.

### *Increased costs to the state*

PSSRU model estimate that there will be around 141,500 self-funding care home residents in 2014/15. Using data about the distribution of cross-sectional lengths of stay in a care home, it is possible to approximate how many of these people will have been resident in a care home for two years or more.

The distribution of lengths of stay is highly uncertain. Evidence from Netten et al (1998) "1996 Survey of Care Homes for Elderly People Final Report" (table 2.3), suggests that around 50 per cent of a sample of older self-funders in care homes had been resident for two years or more. However, this should be seen as an upper limit, because, since the Netten study in 1996, there has been development of other housing with care approaches. It is therefore likely that the average level of dependency of self-funders in care homes has increased. This would mean that the average length of stay in residential care has probably fallen since 1996.

We therefore assume that around 35 to 45 per cent of self-funders in residential care will have cross-sectional lengths of stay of more than two years. This suggests that there will be around 50,000 to 65,000 beneficiaries of this policy.

We estimate the increased cost to the state of this policy by multiplying the number of people who would receive state support after 2 years (i.e. 50,000 to 65,000) by the unit cost of care in a residential care home, ie overall costs minus accommodation costs. We assume that the cost of care comprises approximately half the total fee for residential care. Note that the analysis does not assume that councils will meet especially high care costs but that they will meet such care costs as they generally consider appropriate.

This cost estimate also assumes that providing free care for anyone in residential care for more than two years would have minimal demand effects and that the interaction between spend-down and the policy would be small. This is because the significant up-front cost of having to fund two years of residential care home prior to receiving state support would be a significant deterrent to people who would not otherwise enter care homes deciding to enter residential care in order to benefit from the new policy. Also note that people would still face the costs of accommodation under policy; we assume that this would also act as a deterrent against any increase in demand.

### *Reduction in costs of Attendance Allowance and DLA (care component)*

State-funded care home residents have their AA/DLAc discontinued after 28 days of stay, under current practice. When more care home residents become state funded, they will therefore lose their entitlement to AA/DLAc (note that they are assumed to lose their AA/DLAc on the first day that they become state funded). We estimate, in the absence of firm data, that the annual saving to the state on AA/DLAc would be broadly around £100 million. This would be consistent with an assumption that some 75 per cent of the residents gaining from the policy of free care for anyone in residential care for more than two years lose AA.

### *Reduction in private purchase and increase in user charges in residential care*

We assume that the increase in public expenditure displaces individual private expenditure on care in residential care homes. The reduction in private expenditure is therefore equal to the increase in state cost, subject to the impact of loss of AA/DLAc.

Note that people who receive care free after being in residential care for more than two years will continue to pay their accommodation costs when in residential care. Since more care home residents will become state funded, modelling assumes that private expenditure on accommodation costs will reduce but user charges will increase by the same amount as it is assumed that contributions for accommodation costs will then count as user charges.

## Younger Adults

The cost of the funding options for younger adults have been estimated using a different model. There is a lack of data on younger adults with care and support needs; for example, it is not possible to estimate the amount of unmet need for younger adults under the current system. We show costs and benefits of older people and younger adults separately to reflect the different methodologies used in estimating costs and benefits.

The following box summarises some of the underlying assumptions of the model used to determine the impact of different funding options considered for younger adults.

### ***BOX 2: Key assumptions of the model for younger adults:***

- The analysis is carried out using an aggregate, cell-based simulation model, described in Wittenberg et al 2008.
- The number of younger adults by age and gender changes in line with the Government Actuary's Department 2006-based population projections.
- Marital status rates for physically disabled younger adults change (to 2032) in line with GAD 2003-based marital status and cohabitation projections, while those for learning disabled people remain constant.
- There is a constant ratio of single people living alone to single people living with others.
- Base prevalence rates of learning disability by age and gender are derived from the survey "Adults with Learning Difficulties in England 2003/4" (Emerson et al 2005). Prevalence rates for projection years change in line with the 'middle' projections of the future need for social care services among adults with learning disabilities by Emerson and Hatton (2008, table 4). The prevalence rates of physical disability by age and gender remain unchanged as reported in the 1996/7 FRS
- The proportions of younger adults receiving informal care, formal community care services, residential care services and disability benefits remain constant for each sub-group by age, gender, client group, disability and other needs-related characteristics.
- The real unit costs of social services rise by 1.5 per cent p.a. from 2010/11 to 2016/17, and at 2 per cent p.a. in real terms in all other years considered in the analysis.

#### *Stage two: free care for anyone in residential care for more than two years*

- There would be no increase in the demand for residential care as a result of a change in funding systems: while care costs would be covered by a universal system, accommodation costs which contribute a significant proportion to the total costs would be unaffected.

#### *Stage three: Comprehensive system*

- As for stage two, there would be no increase in demand for residential care as a result of a change in funding systems.
- A shift to a universal care system would have no significant effect on the demand for community or residential care services by people with learning disabilities, because in practice most of them already meet the financial eligibility criteria implied by the current means-testing rules.
- A shift to a universal care system is assumed to have an effect on demand for community care services among younger adults with physical disabilities aged 40 to 64, as discussed below.
- Patterns of demand among younger adults with mental disabilities would follow those for users with physical disabilities.

## Key assumptions of the model for younger adults (continued...):

- Note: A non-trivial proportion of younger adults with physical or sensory disabilities are likely to have assets, which currently exclude them from the means-testing system on the basis of their financial wealth. Evidence suggests that investment income within the disabled population rises with age, which suggests that the likelihood of failing the current means test among younger physically disabled adults increases with age.

Analysis of the Family Resource Survey provides estimates of the proportion of younger adults of different ages with a physical disability reporting at least 2 problems with Activities of Daily Living (ADLs) and have non-housing assets over the current £23,000 means-testing threshold. Analysis suggests that assets among the under-40 age group with physical disabilities are minimal.

Age band	Proportion with non-housing assets above the current means test threshold (%)
40-49	15
50-64	25

Modelling assumes an upper and lower estimate of the increase in demand for services:

- Upper estimate:* Assumes that the level of take-up of community-based services among newly-eligible disabled adults would be equal to take-up rates among those eligible in the current system. Note that this is probably an over-estimate of the likely demand effect: the data show informal care receipt to be highest among current non-recipients.
- Lower estimate:* Assumes that only current recipients of privately funded care would take-up state funded care

## Costs to the state

Note that the costs presented in this Impact Assessment consider only cash costs. The opportunity cost of the spending will depend on how revenue is raised to fund the additional state expenditure; this will be considered by the Commission. The full economic cost is therefore likely to be greater than that considered in this analysis.

### Increased costs to the state

If we assume that the Fair Access to Care Services (FACS) and means test assessments stay constant over time, then the ageing of the population and the projected rise in unit costs of care over and above the level of inflation will result in the total costs of the current means-testing system being projected to rise.

Modelling by PSSRU has projected the costs of the current means-testing system, so that we are able to compare the costs of the current system over time with the costs of any potential new system over time. The cost to the state of the social care system is likely to be greater under the alternative funding options considered since they are more generous in the care offer provided.

### Savings to the NHS

There is some evidence that additional money spent (either public or private) on social care substitutes for money spent on health care in the NHS.

The most reliable evidence on the substitution between social care and health care is from the PSSRU analysis of Evaluating Community Care for Elderly People (ECCEP). They found that an additional £1 spent on community services for older people saved 30p in hospital services for highly disabled people and 25p for less disabled people. This relationship however, holds only at the margin. This means that while it is relevant to count these savings for an increase in expenditure on care and support of, say, £100 million, it is less appropriate to apply the findings to increases of expenditure of, say, £1 billion.

The national evaluation of Partnerships for Older People Projects (POPP) programme, which looked at developing services for older people aimed at promoting their health, wellbeing and independence, found that for every £1 spent on the POPP services, there was an average of £1.20 (confidence interval £0.80 to £1.60) additional benefit in savings on emergency bed days. This however related to such projects rather than to general community-based services.

We assume that the first £500 million additional spend on care and support will save the NHS between 25p for each additional spend, and assume that any additional expenditure over £500 million will save the NHS 10p per additional £1 spent. Note that this is only to give an indicative quantification of the savings to the NHS.

Note that this saving to the NHS only holds for additional expenditure spent on care services thereby increasing the total volume of care provided. For additional state expenditure that replaces private purchase, the effect of the NHS is assumed to be zero.

Note that this is separate from the issue about whether more emphasis on low level preventative services, more integrated working, or other measures might yield efficiency savings to the NHS.

#### Reduction in the costs of Attendance Allowance / Disability Living Allowance (care component)

State funded care home residents have their AA discontinued after 28 days of stay, under current practice. When more care home residents become state funded, they will therefore lose their entitlement to AA/DLA (care).

The methodology used for taking account of this saving to expenditure on Attendance Allowance is considered in the discussions of the methodology used to estimate the costs of introducing free care for anyone in residential care for more than two years.

#### Administrative costs

There will be administration costs of implementing and maintaining any new funding system. For example new IT systems or staff training.

Since administrative issues of any new funding system will be decided in the run up to implementation, we do not estimate these costs in this Impact Assessment.

#### Assessment and care management costs

Since there will be more people eligible for state funded care services under the universal Comprehensive and Partnership options, the costs of carrying out needs' assessments and care management are likely to rise.

Modelling by PSSRU suggests that around 400,000 to 500,000 older people would be newly eligible for state funded care services under the Partnership or Comprehensive options. This means that 400,000 to 500,000 more people would need care management every year.

**Table 27: Number of older people receiving state funded care services (and therefore requiring care management) under a universal care system**

Year	Means-testing scheme recipients <i>Thousands of people</i>	Comprehensive scheme recipients <i>Thousands of people</i>	Increase in scheme recipients <i>Thousands of people</i>
2016/17	1,100	1,500	400
2017/18	1,100	1,600	400
2018/19	1,100	1,600	400
2019/20	1,200	1,600	500
2020/21	1,200	1,700	400
2021/22	1,200	1,700	500
2022/23	1,300	1,700	500
2023/24	1,300	1,800	500
2024/25	1,300	1,800	500
2025/26	1,300	1,800	500

The number of additional assessments required as a result of a change in funding system is slightly less than the number of recipients<sup>23</sup>. Table 28 shows estimates for the number of assessments for older people.

**Table 28: Number of additional assessments required for older people under a universal care system**

Year	Means-testing assessments <i>Thousands of people</i>	Comprehensive assessments <i>Thousands of people</i>	Increase in assessment <i>Thousands of people</i>
2016/17	440	596	156
2017/18	452	620	168
2018/19	456	624	168
2019/20	460	644	184
2020/21	484	660	176
2021/22	488	676	188
2022/23	500	688	188
2023/24	512	708	196
2024/25	516	716	200
2025/26	516	728	212

The unit cost of an assessment for an older person is assumed to be £250. This is multiplied by the number of additional assessments for older people to estimate the total additional cost of assessment for older people.

There is also an additional cost of care management with more people receiving state funded care services. For older people, the annual unit cost of care management is assumed to be £840<sup>24</sup>. This is multiplied by the number of additional recipients to estimate the total additional cost of care management.

For younger adults, we assume that the additional costs of carrying out assessment is equal to 5 per cent of the additional cost of providing care. Similarly, we assume that the additional cost

<sup>23</sup> RAP data for 2007/08, suggests that 472,000 older people completed an assessment, whilst 1.2 million older people received services. This suggests that around 40% of recipients of services receive assessments in a given year.

<sup>24</sup> To estimate a unit cost of care management, we estimated the total cost of assessment for older people under the current system based on the assumption that each assessment costs around £250. We then subtracted this from the total cost of assessment and care management for older people (PSSEX data from the NHS Information Centre). We then considered how many older people have on-going assessments in the year (RAP data from the NHS Information Centre) and divided to get the unit cost of care management for older people.

of care management is equivalent to 12.5 per cent of the additional cost of care. This is in line with current patterns of expenditure.

Both the methodology for estimating the costs of assessment and care management for younger adults and older adults is for illustrative purposes only.

### ***Benefits to the individual***

We consider four types of benefits to the individual as a result of a change in the funding system.

- Transfer of expenditure from the individual to state.
- Expenditure on increasing the volume of care activity.
- Value of insurance.
- Distributional adjustment.

This section considers each of these in turn, outlining the methodology behind the estimation and monetisation of the benefits.

#### Transfer of expenditure from the individual to the state

There are three ways in which individuals contribute financially to meeting their care needs:

- *User charges*: Under the current means-testing system, individuals may receive care from the local authority, but, due to their financial means, may be required to pay some user charge. Under the Partnership funding system, some individuals (with high enough needs) would face lesser user charges for care. Under the Comprehensive funding system charges for care will reduce to zero (but AA and DLA care will be taken into account as part of the package). However, under all funding options considered, when in residential care individuals would be required to pay their accommodation costs if they had the means to do so – these costs would be considered a user charge. The overall number of people getting some support from the state will increase under the funding options considered, so that the number of people required to pay user charges (including accommodation costs in residential care) potentially increases.
- *User top-up charges*: Topping up of publicly funded care is not uncommon. A PSSRU study found that 28 per cent of a sample of older users of publicly funded home care also purchased private home care (Darton et al, 2006). Topping up care will remain an option for people in the National Care Service. The modelling suggests that there will be more topping up under the National Care Service as recipients of publicly funded care use some of the resources they gain from no longer meeting user charges or buying care privately to purchase additional care above their publicly funded care package.
- *Private purchase of care*: Under the current means-testing system, some people may not be eligible for care from the state, either because their needs are assessed as being too low or their financial means too high. These people may choose to purchase their care privately. Under the proposed new funding system, all people with a high enough level of need will be eligible for state support, regardless of financial means, will get some contribution from the state. Fewer people therefore purchase their care entirely privately (i.e. under the Comprehensive funding option, the majority of people who purchase care privately have lower needs so that they would not qualify for state support).

## Change in receipt of Attendance Allowance/Disability Living Allowance (care component)

State funded care home residents have their AA/DLA (care) discontinued after 28 days of stay, under current practice. When more care home residents become state funded, they will therefore lose their entitlement to AA/DLA (care).

The cost to the individual is the inverse of the savings to the state.

## Expenditure on increasing the volume of care activity

Under the current means-testing system, charging (in the state system or private system) means that some people with a care need will not take-up formal care services, or will take less care than if the charge was zero. Clearly, if people with a care need receive no formal care and receive no care from family or friends, then they will have some level of 'unmet' need. In addition, other people with a care need may respond to charges by buying less care than if the charge was zero. This behaviour might generate unmet need, depending on how strong their response to charges is. We therefore assume that any additional expenditure, either by the state or the individual, on increasing the volume of care activity in society under any new funding system reduces this unmet need and therefore has some value.

There are two ways in which the volume of care activity received by users may increase.

- *State expenditure*: The Comprehensive and Partnership funding options reduce the point-of-need charges to service users, thereby increasing their demand for care services and increasing state expenditure on care and the volume of care activity received. The cost of this additional state expenditure is considered in the cost section of this Impact Assessment. The benefit of this additional state expenditure is the care that it provides to users of services.
- *Individual expenditure*: As has been discussed, individuals may respond to a better offer from the state by topping up the state offer. Again, the benefit to individuals of this additional expenditure is the care it provides.

We value the increase in the volume of care activity as equal to its cost, since the market price is indicative of the benefit that it provides.

## Value of insurance

In general, the availability of insurance against risks provides a welfare gain for individuals and society where individuals are risk-averse. A risk-averse person may prefer to pay a fixed premium with certainty rather than face a possibility of suffering a loss less than the premium with uncertainty. The enrollee effectively buys a degree of certainty. Individuals who are risk averse may rationally choose to insure against risks though the expected pay out is less than their premium. The difference between the total premiums and the payout is the amount the enrollee is willing to pay for that certainty.

The benefit of providing certainty of provision of care and support services is the premium over and above the actuarial fair premium the population would be willing to pay. In effect, people are willing to pay an insurance premium higher than their expected lifetime costs of care, for the certainty that having insurance provides. The additional amount that consumers are willing to pay to have certainty is equal to the profits and administration costs an insurer would receive for providing the insurance cover. If we can estimate the profit and administration cost of providing the cover, we can, by definition, then estimate the benefit the population will receive knowing that the costs of care will be covered.

The USA has an established market for health care insurance. The proportion of premiums that an insurer pays to cover medical costs is known as the medical loss ratio. Typically, this is in the

region of 80 per cent<sup>25</sup>. We therefore assume that the remaining 20 per cent reflects willingness to pay by enrollees to receive certainty.

We assume that the benefit is 20 per cent of the increase in state expenditure.

### Distributional adjustment

HMT's Green Book provides a framework by which weighted values can be placed on benefits that accrue to different sectors of society. In particular, it gives weights based on an underlying utility function which links personal utility to income. The underlying concept behind these weights is the diminishing marginal utility of consumption. The population is split into income quintiles and given the following weights:

**Table 29 Distributional adjustment weighting from HMT Green Book**

Quintile	Bottom	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	Top
Weight	1.9 – 2.0	1.3 – 1.4	0.9 – 1.0	0.7 – 0.8	0.4 – 0.5

*Source: HMT Green Book, Annex 5*

Older people in receipt of long-term care are believed to fall into the bottom, 2<sup>nd</sup> and 3<sup>rd</sup> income quintiles because even the wealthiest older people (who represent the main beneficiary group) are in the middle of the income distribution of society at large. The exact distribution is unknown. For illustrative purposes, the distribution is assumed to be 70% in the 3<sup>rd</sup> quintile, 20% in the 2<sup>nd</sup> quintile and 10% in the bottom quintile. This provides an equity weight of:

$$W = (70*1 + 20*1.4 + 10*2)/100 = 1.18$$

We then assume that some of the population in the bottom and 2<sup>nd</sup> quintiles already receive long-term care funded by the state under the current system and adjust for that accordingly. Let's assume that all individuals in the bottom quintile already receive care services funded by the state and half of those in the 2<sup>nd</sup> quintile receive care funded by the state. The weighting coefficient becomes:

$$W = (70*1 + 10*1.4 + 0*2)/80 = 1.05$$

Therefore, the distributional gain is assumed to add an additional weight of 0.05 to the increase in state funding on older people as a result of a change in funding system. Note, however, that the uncertainties around this estimation mean that this distributional adjustment factor is indicative only.

Note that, in line with the argument that the distributional impact should concern the marginal utility of income, we have estimated the distributional impact on the basis of the *income* of beneficiaries of the policy change. The methodology underlying the weighting provided in the Green Book suggests that assets are only relevant to the extent that they yield a consumption stream. However, older people are, generally speaking, asset rich; having benefited from the rise in housing prices over the last few decades. An extra pound may therefore yield an asset rich elderly person less utility than someone else with similar income but fewer assets. If we considered this in the distributional weighting, then the additional weight used to make the adjustment is likely to be lower. The distributional adjustment used in the estimation of the net present value should therefore be seen as illustrative of the possible effect.

<sup>25</sup> <http://healthcare-legislation.blogspot.com/2009/11/does-actuarial-value-trump-medical-loss.html>

We assume the same distributional adjustment factor for younger adults. Younger adults in receipt of care are, on average, lower in the income distribution compared to older people receiving care; perhaps because they have had to retire early as a result of their care need, or maybe never had the opportunity to work. However, those who would benefit from the reforms discussed in this Impact Assessment are, by definition, the wealthiest of this group of individuals. This is because people benefiting from these reforms are either i) not eligible under the current means-testing system based on their income/wealth; or ii) making means-tested user charges. Indeed, PSSRU modelling of the effect of the reforms on younger adults assumes that a non-trivial proportion of people with physical or mental disabilities aged 40 to 64 are likely to have assets. It is those people who are assumed to benefit from these reforms. We therefore assume that they are similar to older people benefiting from reforms in terms of their income distribution.

Note that these distributional adjustments do not take account of the way in which revenue to fund the system would be raised, to be recommended by the Commission.

## Annex C: References

References are in alphabetical order by author.

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