

Consultation response

Call for Evidence on the Future Funding of Care and Support

Ref: 0511

January 2011

All rights reserved. Third parties may only reproduce this paper or parts of it for academic, educational or research purposes or where the prior consent of Age UK has been obtained for influencing or developing policy and practice.

Name: Lizzie Feltoe
Email: elizabeth.feltoe@ageuk.org.uk

Age UK
Astral House, 1268 London Road
London SW16 4ER
T 020 8765 7200 F 020 8765 7211
E policy@ageuk.org.uk
www.ageuk.org.uk

Age UK is a charitable company limited by guarantee and registered in England (registered charity number 1128267 and registered company number 6825798). The registered address is 207-221 Pentonville Road, London N1 9UZ.

About the consultation

The Commission on the Funding of Care and Support was set up in July 2010 to review the evidence on funding for care and support in England, and make recommendations for reform. The Commission is chaired by economist Andrew Dilnot, and Dame Jo Williams and Lord Norman Warner sit alongside as Commissioners.

The Call for Evidence, to which this paper responds, was published in November 2010. It is a statement describing the thinking of the Commissioners after conducting their initial research and deliberations. It also begins to test ideas for reform.

The Call for Evidence outlines the challenges facing the future funding of care, such as demographic change and future alteration in the balance of wealth, and the key strengths and weaknesses of the current care funding system. It asks for views on whether the Commission's initial findings are sound, and calls for more evidence to support policy change. It also asks for detailed ideas and suggestions about how care and support should be funded in the future.

Key points and recommendations

Age UK welcomes the work of the Commission and its initial analysis of the challenges facing future social care funding. We agree with a great deal of the principles outlined in the Call for Evidence. We have added discussion and detail to challenge or support some of the key points.

Opportunities and challenges

There is significant uncertainty with respect to the rate at which demand for care will increase, and alone the number of people in late old age is not necessarily a good indicator of need. Overall mortality levels will predict care requirements to an extent, but the incidence and duration of disability at the end of life may increase or decrease, with lifestyle change and medical developments. The unit costs of quality care and the availability of informal care are also unknown. With future demand for care so difficult to predict, a significant degree of flexibility should be built into the new system.

Age should not be used as a proxy for wealth or ability to pay. A reformed funding system should not assume that all older people will be more wealthy than younger people. Care should be provided on the basis of need, with wealth a secondary consideration. The first priority of the funding system should be to protect those with little or no wealth and ensure that the care they receive is of high quality.

Strengths and shortcomings

Age UK partially agrees with the Commission's assessment of the strengths of the current system, but we found its analysis too favourable in many instances.

The current system does not provide an adequate 'safety net' for a number of reasons: the threshold is too high for many people to qualify for support; the quality of life achieved through provision of the safety net is constrained and inadequate; and that support provided tends to be 'one size fits all'.

Age UK disagrees with the Commission's assessment that the current social care funding system is preventative. Older people are frequently unable to access support until they are at a substantial or critical level of need as a result of: tight eligibility criteria; a general failure to provide basic early intervention services; and constraints on Disabled Facilities Grants and Supporting People funding. A reformed funding system needs to enable early intervention, to prevent harm to quality of life, the need for intensive services, and increased financial cost to the state.

On a related point, we challenge the assertion that the system is responsive to local needs, rather than just subject to many different local rationing decisions. Service access is so restricted in many areas that it cannot be a result of rational decision-making about how best to meet local need.

We agree with the Commission's assessment that there is unmet need in the system. A starting point for quantifying levels of unmet need must be a definition of what the social care system should be providing, in terms of the outcomes it will support.

We agree that the current social care system does not provide good value for money. This is partially because needs are not avoided through preventative measures. The price of care is poorly correlated to quality of service.

The system is currently very complex and not easy to navigate successful. Reform must make it easier to access, plan and pay for care.

Age UK principles for reform of funding

1. There needs to be a **broad consensus** about the funding solution put forward. This will ensure its success as more people will 'buy in' to the need for reform and increases to funding contributions. A settlement across political parties is also essential.
2. There should be **many more winners than losers**, in order to make the proposed changes palatable to individuals. This means more people should be able to access care and support services, without this being simply a substitution for existing disability benefits.
3. **General taxation should continue** to make a large and growing contribution to the costs of care. This should be at no less than today's spending on social care and disability benefits combined, and then remain at or above this proportion of GDP in the future.
4. **New collective funding arrangements** are essential to meet rising costs and offer a degree of risk pooling for everyone. We prefer models of general or earmarked taxation rather than hypothecated social insurance. The money could come from a combination of revenue streams, including charges linked to assets, to ensure affordability and fairness.
5. **A universal financial contribution** towards care costs should be available, regardless ability to pay, subject to affordability. The 'offer' could be one or more of a flat-rate contribution, a sliding contribution linked to individual payments, or a limited liability scheme.
6. **New financial products to meet remaining care costs** should be facilitated and promoted by government. Models should include viable private insurance models and a range of options for paying at the point of need.
7. **Payments to support the additional costs of disability** should continue to be available on a non means-tested basis as a nationally, legal entitlement. This will ensure no one is materially disadvantaged by their disability, and prevent the need for more intensive and expensive services.
8. **A national legal entitlement** is essential. This should include (1) a flat-rate disability costs payment; (2) the right to a personalised assessment; (3) an entitlement to the resources required to meet nationally-determined acceptable outcomes (subject to personal contributions from mid and high income groups). Payments should only vary in line with regional differences in the costs of meeting these outcomes.

9. **Information, assessment, advocacy and brokerage** services should be funded generously so that they are available to everyone. This will help ensure informed decisions and appropriate use of resources.
10. There should be complete **age equality** in the availability of care and support resources and the outcomes the system aims to achieve.
11. A reformed system should be **carer neutral**. Those who want to provide informal care should be supported to do so, through benefits and services, but no one should be forced into a caring role.
12. There must be **alignment with the NHS and other local government services**, especially housing support. The NHS should continue to support health needs in care homes, and jointly commission preventative services with councils.
13. The funding system should be **flexible to promote diversity of provision**, including different types of tenure and the option of commissioned services over cash payments. Funding should encourage innovation and positive risks.
14. **The proposals must take account of poor trust in Government**. Faith in solutions for national challenges is often a factor in their success. To be successful, the recommendations put forward by the Commission needs to be accompanied by an institutional framework that develops trust in the settlement. Independently supervised guarantees about entitlements, payments and what to expect will help the public understand and accept a new settlement.
15. **A permanent body** is needed to take responsibility for ongoing analysis of demand and costs of care. It would advise the Government on financial issues concerning care, including revenue raising and possible tariff setting.

Bringing our principles to life: Age UK's 'straw man' illustration

Overview

1. A single national system of legal and financial entitlements
2. An ongoing role for local government in assessment, support and shaping the care market, and responsibility for 20% of the costs of the system
3. State facilitation of financial products for voluntary top-up financing, including pre-paid insurance, immediate needs annuities, deferred payment and equity release.
4. Collective funding from general taxation and new compulsory payments (earmarked taxes, not a separate social insurance scheme)
5. Flexibility designed-in, with a national agency to review the effectiveness and cost of the system, and make proposals for overall budgets and scaling entitlements up or down.
6. Separate responsibility for the NHS for close-to-hospital care, and for local public services for commissioning early interventions and community-wide services.

Entitlements

1. Free NHS personal care and rehabilitation for 6 weeks following hospital discharge
2. Free integrated, personalised and portable assessments, stating outcomes to be achieved, carried out by councils
3. Free information and support to arrange care, available from councils
4. Free information and support for carers, available from councils, and a review of benefits for carers (aged above and below state pension age) in light of the reform package.
5. A single support payment, comprising
 - *For everyone whose disability gives rise to extra living costs*, a flat-rate payment, at no less than the lower rate for AA/DLA (non-means-tested)
 - *For everyone with support needs*, a personalised allocation of the resources required to meet assessed outcomes, on a means-tested basis (precise figures are illustrative)
 - *For the poorest*, 100% of resources to meet personal care and 80% of care home accommodation costs
 - *For the richest*, initially 50% of the resources to meet personal care costs and 0% of care home accommodation costs
 - *For the richest*, after £50,000 of expenditure incurred, 90% of resources to meet personal care and care home accommodation costs
 - The flat-rate payment would be uniform across the UK and carer-blind. The personal allocation would vary across the country to reflect variations in costs of securing identical outcomes, and take account of reasonable contributions from carers.
 - An independent agency would set a nationally consistent threshold for eligibility (comparable to FACS 'moderate needs'). It would undertake market analysis to set local payment tariffs, based on the resources required to provide high quality support that is sufficient to meet different levels of need, in different parts of the country.
 - Service users would be free to spend more or less than allocated. People who would face difficulties managing their own payments would have the option of alternative formats, including professionally arranged support.

Financing

1. General taxation would provide a fixed contribution to the system relative to GDP
2. Additional earmarked charges would be introduced at launch, to fund the shortfall between general taxation and the costs of the new entitlements. These would rise over time as this gap widened.
3. Earmarked charges could be a combination of the following: (a) the conversion of 'temporary' tax rises introduced to close the deficit into permanent care-related taxes from 2015 (eg ½ p on National Insurance); (b) the introduction of National Insurance for people over State Pension Age; (c) a modest levy on all inheritances and lifetime gifts; (d) a review of Capital Gains Tax and other wealth-related taxes
4. A national budget would meet 80% of costs with councils paying 20% to ensure they had an incentive to invest in prevention and appropriately assess eligibility. An offsetting reduction in

local government formula grant, would lead to an increase in their financial autonomy.

Introduction

Age UK welcomes the broad remit of the Commission's work, including: a focus on finding a partnership between individuals and the state; examining the contributions of all public spending streams; and the assessment of options to protect assets from all risks arising from care needs (not just personal care). In addition we think the Commission should place emphasis on expanding the total resource available to eliminate unmet need and improve quality.

We are pleased to see emphasis on partnership between individuals and the state, and the illuminating data on current state spending. We believe that an essential starting point for the Commission's work is to accept that the state's contribution to care and support will need to rise in line with rising care needs and to address existing levels of unmet need.

It is important to note that there has been considerable movement over the last 30 years in the mix of funding between the individual and the state. In the past eligibility criteria were set at lower thresholds, charging requirements were less onerous, packages of support more generous, and the boundaries of the NHS more loosely drawn. At the same time rising personal wealth and home ownership has meant more people now do not meet criteria for state funding. This has not only increased the share of contributions made by individuals (to over half of social care spending on over-65s) it has also constrained total demand and increased levels of unmet need. There has also been significant fluctuation in the fiscal landscape, with rates of growth now being suppressed well below their recent trends. It will be important that current short term pressures on public spending do not shape very long-term decisions. In summary, it is essential that the Commission does not view today's level of state funding or the current mix between state and personal contributions as a default. It should instead focus on the outcomes that need to be secured, and assess how these can be fully achieved, while minimising spending for the taxpayer.

1. Do you agree with the Commission's description of the main opportunities and challenges facing the future funding of care and support?

Age UK agrees with almost all of the points made by the Commission. In response to this question we provide additional insight or nuance to the Commission's analysis.

We particularly welcome the paper's focus on uncertainty, and the need to plan with wide margins of error in mind. This underscores the need to design a flexible funding solution, which can respond to changing patterns of demand and supply in the future.

Changing demographics

Mortality – the most important demographic driver of demand for care is mortality, rather than numbers in late old age per se, since proximity to death is the most important determinant of need for care in old age. Research has shown that the increasing numbers of people in proximity to death will drive up healthcare costs, although to extent to which this happens depends on the methodology used.¹

'Dependency ratio' – commentators and policy makers (including the Department of Health) have exaggerated the pressures facing the UK by focusing on the ratio of people aged above and below 65 (and/or state pension age). From the perspective of national and personal finances it is more appropriate to focus on a ratio of economic activity (workers : non-workers). With rapid increases to the average age of exit from work over the last 15 years this has been rising less quickly and will not fall in an alarming way as long as we are able to extend working life at the current rate.

Older people's contributions – the Commission should be mindful that older people contribute a significant amount of public revenue through VAT, council tax, income tax, inheritance tax etc. In considering tax-funded options, it is important not to assume that the source of funding need inevitably be payroll taxes paid by under-65s. Indeed part of the Commission's work could focus on considering options for shifting the balance of taxation towards older people with high assets who can afford to pay.

Changing care needs

Morbidity - we agree there is huge uncertainty with respect to likely levels of disability and ill health sufficient to trigger the need for social care. While the numbers of people in their final years of life is fairly predictable we cannot be at all certain about the incidence and duration of future disability requiring care and support. If age-specific disability levels remain as they are today there will be very rapid increasing demand for support services. In particular, this assumption informs the projection that rates of dementia will double between 2001 and 2040.² However, we are hopeful that these assumptions are too pessimistic, and people experience improvements in health as well as life expectancy. At present the headline indicators indicate that healthy life expectancy is rising but not as fast

¹ Estimating the future healthcare costs of an ageing population in the UK: expansion of morbidity and the need for preventative care, Caley and Sidhu, Journal of Public Health, June 2010.

² The effect of dementia trends and treatments on longevity and disability: a simulation model based on the MRC Cognitive Function and Ageing Study, Jagger, Matthews, Lindesay, Robinson, Croft, Brayne, Age and Ageing (2009) 38 (3) 319-325.

as life expectancy.³ More analysis may be needed with respect to specific conditions, in particular dementia.

Meanwhile we agree it is essential that a reformed funding system is flexible and responsive so that a framework can operate consistently whilst being able to adapt to medium and long term uncertainty regarding demand. We must not be in a position in 20 years where a short-term solution has been implemented and is not sustainable over time.

Changing wealth and assets

Income and affordability – the Commission rightly places emphasis on changing patterns of asset ownership. However, it should not disregard future projections of income, as this is likely to remain a key driver of the affordability of payments for care, either at the point of need or through any new risk pooling arrangements.

On average, incomes in later life are expected to continue rising, due to increased private pension income and reforms to the state pension income. However, levels of pensioner poverty and reliance on means-tested benefits are not projected to fall over the next 40 years, on the basis of current policies (Age UK is sponsoring research on this issue by the Pensions Policy Institute which we will make available to the Commission when possible). Any policy solutions involving better use of assets will need to be designed on the basis that high numbers of people are ‘asset rich, cash poor’. It is also worth bearing in mind that there may be other potential calls on assets for low income groups, for example to boost consumption or adapt and modernise the home.

Asset inequalities – the Commission is right to point out that people around retirement age have, on average, higher wealth than other age groups, and they are likely to maintain high levels of wealth into late old age. There is of course wide dispersion, with wealth inequalities in cash terms highest among ‘baby boomers’ than any other age group.⁴ It is our strong view that age should not be used as a proxy for wealth; instead if revenue is to be raised from assets, this should be done directly targeting all age groups. This would secure fairness between older people who are not wealthy and younger people who are.

Future asset distribution – in our view there is considerable uncertainty regarding the future assets of today’s under-55s, as the interactions of age and cohort effects are unclear. Today’s discussions about the intergenerational distribution of housing wealth usually ignore the obvious point that there is a broadly stable stock of housing. This means that when future generations reach later life they are likely, through inheritance, to come to own property assets to a similar extent as their parents do today. This suggests there is no need to design separate funding systems for the baby boomer generation and younger age groups. Worryingly, it is likely that future generations will have wide inequality in access to wealth, as the effect of handing down wealth to younger generations is felt. Those children of older people who have profited from rising house prices will be more likely to be wealthier in their own old age. The funding system will always need to support those with little access to personal funds to pay for care. The care provided by the state for these people must not act only as a ‘safety net’ but must be good quality and comprehensive.

³ Office for National Statistics, Nov 2010, www.statistics.gov.uk/cci/nugget.asp?id=934.

⁴ Monitoring poverty and social exclusion 2010, Joseph Rowntree Foundation, www.jrf.org.uk/sites/files/jrf/poverty-social-exclusion-2010-full.pdf.

Changing social and technological trends

Informal care – there is a high level of uncertainty with respect to the availability of informal care from family and friends. The Commission is right to highlight the potential for a gap between the provision and supply of informal care. However, it is unclear whether the propensity of different demographic groups to care will remain unchanged as need within families rises. As informal care is such a critical part of the whole care and support system, small changes here could have bigger impacts elsewhere affecting demand for care. It is an area where we think more research is necessary.

The paper highlights some of the downward pressure on the supply of carers – and we would add others, such as rising family mobility, including international migration. However there are also trends pushing in the opposite direction:

- Rising life expectancy means that adult children will in future be older when their parents' care needs arise and more are likely to be retired or semi-retired themselves.
- Improvements in male life expectancy should reduce the number of single women, and increase the availability of care within couples.
- The availability of flexible working options should mean more people are able to combine caring and work.

It is important to note that the supply of carers is itself dependent on policy decisions. Other things being equal, more carers are likely to be available if there is good support for carers (practical, emotional and financial) and widening opportunities for flexible working.

However caring roles should not be equated with the provision of personal care. Family and friends may continue to provide essential support (even from a distance), even if they chose not to provide intensive hands-on care. A new care and support system should be designed to support and encourage people who want to care, but avoid the assumption that anyone will provide care of such intensity that their own health and wellbeing is put at risk.

Changing expectations of services – a trend the paper does not identify, which should be considered, is the expectations people will have of care provision in the future – and of the public sector's role in delivering this. Generally speaking personal and health services are 'superior goods', which people wish to consume in proportionately higher quantities as societies grow richer (irrespective of demographic change). It is therefore likely that people in the future will both demand better quality and quantity of state provision, and be prepared to spend more on care from their own resources.

Policy changes will also drive expectations and consumption patterns. For example the current political emphasis on 'personal responsibility' and the Big Society - and the announcement of heavy spending cuts - may lead to a shift in expectations, with communities and individuals consuming more informal and privately funded care, as state funded care does not rise in line with demand. However, the effect that this has on individual behaviour is not known and is difficult to predict without a behavioural economic analysis.

Whilst current political trends and spending pressures may only last a few years, they may for the time being affect what people expect a council to provide. Individual awareness of withdrawal of state services and the pressure for increased personal responsibility could

result in more planning and preparation by that individual; or it could result in the reverse, with individuals shrugging off their responsibility and failing to plan.

Supply of care services – the paper does not discuss the considerable uncertainty with regard to the costs of supplying care services at the volumes that will be required. The Commission will need to take a view on likely cost pressures in the sector. In recent years costs have risen annually by around 4% in real terms⁵, but the Government believes increases can be suppressed for the next four years.

Over the long term, it is not clear what level of funding will be required to stimulate sufficient supply to meet all needs. In particular, we do not know how much it will cost to recruit, train and retain an expanding workforce with the skills and professional ethos to deliver the quality and quantity of care society will expect. Although there are non-financial factors, such as the perceived worth and status of caring work, the question of labour costs is primarily economic, with the growing care industry needing to out-compete other low paid sectors.

⁵ Personal Social Services Expenditure and Unit Costs, England Final 2008-09.

2. Do you agree with the Commission’s description of the strengths of the current funding system, and its potential shortcomings? Do you think there are any gaps?

We welcome the Commission’s attempt to analyse which elements of the current system work well and which do not. We agree with much of what the paper says, but also have some significant caveats.

Identified strengths of the current system

1. **‘Safety net’** – Age UK partially agrees with the assessment that the current funding system provides a ‘safety net’. However we have many qualifications with respect to its efficacy today.

First, the threshold for access to the ‘safety net’ of provision is too high for many people to qualify. This is because in most parts of England care needs are required to have developed to ‘critical’ so that ‘life is or will be threatened’ or someone has an ‘inability to carry out vital personal care tasks or family roles’⁶. Age UK believes that the threshold for accessing this care should not be so high that only emergency cases or people in severe need are able to qualify. Apart from discharging society’s responsibility to those who are in a vulnerable position, there is an economic logic to providing services earlier, when they may prevent future expense arising across the public sector.

Second, the ‘safety net’ of the current system fails because the quality of life that it seeks to secure for people who meet eligibility criteria is very constrained, especially for older people due to endemic age discrimination. Care and support should be comprehensive enough to guarantee that people remain safe and are assisted with basic physical functions; but it should also help to avoid intolerable levels of social isolation, inactivity and lack of stimulation; and help to maintain basic building blocks of personal identity such as dignity and domestic order. To command public trust the state has to provide people with a much stronger guarantee that a basic safety net that will support a tolerable quality of life.

Third, levels of support are not always personalised to an individual’s needs. Since state care is, for many people, the final safety net, it needs to be provided on the basis that it has to meet individual identified needs. A ‘one size fits all’ approach in which the state provides a fixed level of funding (as is the case with DLA or Attendance Allowance) will fail to do this. Many Local Authorities have established practice on this and use crude Resource Allocation Systems. The need for allocating personalised levels of support has strong implications for the process of assessment and decision making – and limits the likely scope for savings in this area.

Fourth, for older people who own assets (but may still have low incomes), the capital limit of £23,250 (in 2010-11) prevents access to state support with the arrangement, as well as the payment of care. For those who are excluded from provision of care there are significant disadvantages in being forced to arrange care without advice or guidance from the Local Authority. The Commission’s paper states “people with assets over £23,250 receive no state support and need to fund their own care” (page 6). However guidance and legislation

⁶ Prioritising Need in the Context of Putting People First, Department of Health, 2010.

states that if these people need care in their own homes they are entitled to state support even though they might have to pay the full cost. This means they are entitled to assessment and to have the state take responsibility for arranging and monitoring their care. Meanwhile, if they have to go into care homes and are unable to arrange it themselves, or have no one willing to do it for them, Local Authorities also have a duty to step in. These duties are crucial for people who, whatever their income or wealth, cannot arrange their own care, especially those with dementia. We think it is an essential dimension of 'safety net' provision, which councils are generally not discharging to the extent that they should.

2. Personalisation – Age UK firmly believes in personalisation as a positive and welcome direction for the development of services. Putting older people at the centre of their care is the best way of ensuring that appropriate and welcome services are available for them, and that their care needs are well met. Personalisation can take many forms, including Direct Payments and Personal Budgets, but also emphasise that personalisation can be achieved through the provision of council-commissioned services, arranged through, and with advice from, a social worker. This is particularly important for emergency interventions or when needs are fluctuating and where a payment of money is not always suitable. The future system of funding for care and support should not preclude any particular form of social care provision. In particular we are concerned about the current emphasis on Direct Payments as the default for older service users, as there is little evidence that these improve outcomes.

3. Prevention – prevention should be a key element in the future system of care provision, and the funding system should support investment in services which are preventative. However, Age UK does not agree with the Commission's assessment that this is a strength of the current funding arrangements and provision. In the 1980s it was common for councils to offer 'home help' services to provide support with domestic tasks to people without significant disabilities. In contrast, by the next financial year it is predicted that 80% of councils will only provide care for people assessed with 'substantial' or 'critical' needs. Many councils are planning to cut services further to 'critical' only.⁷

Prevention needs to be a top priority in order for care costs and provision of services to be managed in a cost-effective way.

- The planning and delivery of care should be designed to achieve a positive reduction in individual care needs, particularly through the extension of re-ablement (including the regaining of skills and confidence, rather than just physical functioning).
- Entitlement to services should be available earlier. In particular it is our firm view that people assessed as having 'moderate' needs have legitimate requirements for care and support.
- Community-wide services with proven benefits for the wider health and care economy should be available without strict assessment arrangements. These should include for example handyman schemes, advice services, social and mealtime opportunities, and exercise classes, and floating and on-site housing support. These services could be available free or at a reasonable charge. For individuals who want to access these early intervention services there should be readily available services in their local area, and councils should take responsibility for managing this market and ensuring there is adequate provision. They should also coordinate activity to

⁷ Community Care survey, 2010, www.communitycare.co.uk/Articles/2010/09/15/115321/councils-to-deny-social-care-support-to-all-but-most-needy.htm.

identify and encourage take-up of services by people who are isolated or at high risk of needing acute support in future.

- Getting the right equipment at the right time can be very cost effective. Age UK is aware that some Local Authorities have imposed severe limitations on equipment, and access to equipment is very patchy. If equipment is to truly take its place in the preventative agenda then it needs to be more freely available before a person's need for it has become critical or substantial. Disabled Facilities Grants has been shown to produce consistent health gains, prevent accidents and admission to residential care, and contribute to improvements in quality of life and independence.⁸ DFGs are currently underfunded, and many Local Authorities use up their allocation of funding in the early part of the financial year. When considering social care reform the value of additional grants to support people in their own home is necessary.

4. Partnership – Age UK agrees with the assessment that the current care system is a form of partnership between the individual and the state. It is worth highlighting that this can be said of a wide variety of systems, including the Scottish model where payments to meet basic personal care needs are not means-tested. The degree to which the current model of partnership is effective and sustainable is a concern to us. The state's role in the partnership has declined to the provision of disability benefits, except in cases where there are high needs and low financial means. This should not be the default for a reformed system. Setting aside the question of financial support, Age UK envisages an increased role for the state, where everyone who wishes to is able to access information and advice, assessment, brokerage and advocacy through their local council. Currently, Local Authorities do not have powers to charge for carrying out statutory functions such as assessment and care management and this should continue to be the case.

Age UK sees a continuing role for the private and voluntary sectors as providers of services. In most cases we are agnostic about who provides care services, as long as they offer high quality and good value. It is important to note that in-house delivery may well remain the best option for some services, for example emergency support that needs close integration with the assessment process and NHS services. Whoever the provider, the public sector must remain responsible for ensuring that rights and entitlements set down in law are observed.

5. Local responsiveness – in attempting to provide a balanced assessment of the role of local councils we feel the Commission is trying to 'have its cake and eat it'. While we do not dispute the important role of councils in assessing need, commissioning support and shaping and supervising local care markets, we have no doubt that the current lack of clear national entitlements is a huge weakness for the system. It creates uncertainty for individuals, makes financial planning far harder and hinders mobility. Even more seriously, the current divide of responsibilities between local and national government is one of the main drivers behind of the current under-funding of the system.

In our view the current system, for all its local roots, is failing communities where care needs remain unmet and are increasing, without an adequate response from local councils. Where there is a finite provision of funding and increased needs councils are faced with very difficult decisions. However, many councils are setting budgets for 2011-12 which will

⁸ Reviewing the Disabled Facilities Grant Programme, Office of the Deputy Prime Minister, 2005.

actually cut back on care services despite the existing pressures. Relying on councils to make the best decisions, without full financial control, is deeply flawed.

Older people tell us that local discretion over entitlement to services is unfair, divisive and a barrier to mobility, especially where people with support needs want to move to be near relatives. Age UK thinks that local councils should have discretion in how they meet local needs, but we are also convinced that similar levels of need should trigger entitlement to a similar level of support in all localities.

Additionally, Local Authorities, public health services and the NHS should be expected to commission and provide a basic level of cost-effective preventative services, with discretion over the amount and type of provision. This will allow local areas to put in place services which are responsive without building in unfairness and inequality.

Shortcomings of the current system

1. High care costs for some people – Age UK is pleased that the Commission has highlighted the effect of very high care fees on some older people. Older people have repeatedly told us that they would like to see a system that enables people to pool the risk of high costs so that people in mid- and high-income groups are able to avoid catastrophic care costs.

The paper does not refer to the existing options for limiting immediate exposure to cost – namely deferred payment and immediate needs annuities. Measures which can be used to defer fees or use the property to raise an income through rent are rarely applied by Local Authorities as a means of avoiding sale of a house during the older person's lifetime. Similarly the private market for immediate needs annuities seems surprisingly small, given the number of people who might want to cap their liabilities at the point of need.

Age UK has concern not just about those people paying for care home fees, but also those living in their own home receiving domiciliary care. In recent months several Local Authorities have chosen to remove the cap on weekly care fees chargeable, and in those Local Authorities that do use a cap it varies widely, from £60 in Barnsley to £850 in Brighton and Hove.⁹ Whilst this care is also means-tested, someone with a moderate to high income could face using significant amounts of savings and income to pay for their services. Because charging policies are not consistent across the country, it is very difficult to predict the cost someone might face and there is an unfairness in approach to charging.

There is uncertainty with respect to average length of stay in care homes and lack of current data makes future projections more difficult. The Commission's use of 1996 data may be misleading (and unduly pessimistic) as the pattern of care home use has shifted over the last 15 years, with the move in policy towards independent living and support for older people to remain in their own home. As a result entrants to care homes are much more disabled now than a generation ago when the concept of the 'retirement home' still had currency. As a consequence, it is likely that the length of stay in a care home is now much shorter than 15 years ago, unless there have been significant changes in the survival patterns of people with severe frailty and cognitive decline.

⁹ Which? reveals home care postcode lottery, 20 January 2011, www.which.co.uk/about-which/press/press-releases/campaign-press-releases/personal-finance/2011/01/which-reveals-home-care-postcode-lottery/.

On a related note it may be important for the Commission to assess scenarios for the future demand for and cost of extra care housing and other new models which may come to replace a significant proportion of care home places in future.

2. Unmet need – Age UK agrees that there are huge levels of unmet need in the social care system. We know this because we hear from many older people and carers that they have been unable to qualify for Local Authority assistance in arranging and funding services because their needs weren't high enough, or they had too much wealth. Frequently people in this situation do not purchase care and support privately. Our qualitative evidence has been repeatedly confirmed using modelling based on robust surveys of disability-related needs, most notably in the analysis prepared for the Wanless Review. We strongly endorse the emphasis that the study placed on moving from a 'current service model' scenario to one where 'benchmark' care needs are met.¹⁰

Revisiting the analysis of the Wanless Review also underlines the point that unmet need is not a new phenomenon of the last five years. The data reported in the Commission's paper with respect to spending since 2004/05 is particularly alarming because it builds on a level of provision that was already totally inadequate.

It is however important to note that unmet need cannot be defined with any accuracy until there is a common understanding of the outcomes that social care should be supporting. For example, if the desired outcome is to keep people alive the needs that are unmet will be much lower than if the outcome is to provide a decent quality of life and to respect people's dignity and human rights. The redesigned social care system should be firmly underpinned by explicit national outcomes which are generous and support people to have a high quality of life.

3. Value for money – we are in strong agreement that the balance of total public spending on later life is inappropriately skewed away from care and support. The flipside of this observation is that a period of rapid 'catch up' growth in care spending does not imply a large percentage rise in total age-related spending.

We agree that the Commission should review the availability of support from all sources. However we are not convinced that the mere fact of overlapping entitlements indicates inefficiency or poor value for money. This question has been raised with respect to disability benefits, which the Wanless Review and the previous Labour Review considered as a source of funding for improved social care. We believe that many of these proposals have not been based on a clear understanding of the role disability benefits play and the characteristics of their recipients.

The importance of disability benefits – Attendance Allowance and Disability Living Allowance

Attendance Allowance (AA) and Disability Living Allowance¹¹ (DLA) are non-means-tested social security allowances which are paid to help with the costs of disability. In the past it has been suggested that disability benefits could be integrated into the care and support system in order to target resources on those in greatest financial

¹⁰ Securing Good Care for Older People, The Kings Fund, 2005.

¹¹ The Government is proposing reforms to DLA which is for people disabled before the age of 65 but it will still be a non-means-tested extra costs benefit.

need and to remove duplication.

However Age UK strongly believes that the current entitlements should continue (albeit with scope for integration within a single system). These benefits provide highly valued flexible support which promotes independence and helps with the costs of disability.

Targeted support

AA and DLA are targeted at people who are 'severely disabled' as set out in legislation which provides the criteria that people have to meet. This is judged using a detailed application and assessment process. It can be difficult for many older people to admit to needing help and they often delay making an application. If there was an intrusive means-test as well as an assessment of disability this would act as an additional barrier. Ensuring people have the support they need as soon as possible helps people maintain independence. Without this people may require support through social care or health services at earlier.

Although the benefits are not means-tested research shows that they predominantly support lower income disabled people. Nearly half (48%) of AA recipients have pre-benefit income below the standard Pension Credit guarantee credit level as compared to just over a fifth (22%) of those not in receipt of a disability benefit¹². These findings are likely to reflect the higher levels of disability among people from lower social economic groups and the lower probability of people with disabilities in higher income groups making a claim¹³. Any withdrawal of disability benefits is therefore likely to disproportionately affect those with lower incomes.

The impact of AA and DLA

Disabled people face many additional costs in addition to the need to pay for care. Examples include higher fuel bills, special food, transport, laundry, communication needs and extra clothing costs. In these cases, receiving cash is important, giving individuals flexibility about how they meet their own needs, and avoiding the need for care.¹⁴

Our research found receipt of disability benefits has a hugely positive impact on older people's wellbeing and has the ability to transform lives. In an Age UK survey of over 650 people benefiting from our information and advice services nearly 90% had applied for AA and DLA¹⁵. The main items they used the allowances for were practical help and care services or additional living costs such as heating and food which are often higher for people with disabilities. Older people told us how the extra money enabled them to keep well and independent. For example people susceptible to the cold because of health problems could maintain a warm home; people could make payments for help such as shopping and cleaning which enabled them to remain at home and could cover the costs of special diets or extra laundry. These uses of the allowance seem very much in line with the policy intention of helping people meet the costs of disability and the quotes below demonstrate the impact.

¹² *Attendance Allowance and Disability Living Allowance claimants in the older population: Is there a difference in their economic circumstances?* Hancock, Morciano and Pudney, 2010.

¹³ Evidence from Universities of Essex and East Anglia to Health Select Committee
<http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/22/22ii.pdf>

¹⁴ Review of international evidence on the cost of disability, Stapleton, Protik and Stone, DWP, 2008.

¹⁵ *Transforming lives* Age UK, 2008

'Attendance Allowance has made a big different physically and emotionally. My life has taken on more meaning'

'I feel the cold extremely because of my health.....Receiving Attendance Allowance means we have been able to leave the heating on during the day without worrying about the bill'.

'Attendance Allowance enables me to live more the way I used to'

In summary from feedback we have had older people value AA because:

- It enables older people to buy in whatever they need to remain independent in their own homes.
- People can spend it on whatever they think will improve their situation. This is very individual as health conditions vary and change over time.
- There is no book keeping. AA compared favourably with personal budgets which some had indirect experience of from friends who found them onerous.
- They can maintain friendships, hobbies and interests leading to social inclusion and stronger mental health.
- It enables people to retain their dignity. Older people don't feel like a burden.
- It is not means tested therefore there is no stigma.

Recipients of AA and DLA are reported to use the benefit to meet the expenses of personal care, transport, food, fuel, home maintenance, healthcare, telephones and computers, and social activities.¹⁶ Research has also highlighted that recipients often feel the benefits they received had a preventative advantage so that they were able to stay at home rather than move into a care home, and they were able to maintain their health.

According to research carried out for the Department for Work and Pensions, people receiving DLA thought that they benefited because it helped them maintain independence and control, meet some of the extra costs of disability, improve quality of life, keep jobs, enhance physical and mental health, maintain warmer and cleaner homes and relieve financial pressures.¹⁷

Should AA and DLA be treated differently?

DLA is awarded to people who become disabled and make a claim before the age of 65 although in payment it can continue. Both DLA and Attendance Allowance are intended to help with the extra costs of disability – not to provide basic income maintenance or replace earnings or pensions. The research referred to above found no difference in the pre-benefit income between people aged 65 receiving DLA and those receiving AA. We believe people should be treated based on their needs, not an arbitrary age, We would strongly oppose any moves to remove entitlements to disability benefits from older groups, especially given AA is already less generous because it does not include a mobility component.

An overlap with care services?

¹⁶ The impact of Disability Living Allowance and Attendance Allowance: findings from exploratory qualitative research, Corden, Sainsbury, Irvine, Clarke, Department of Work and Pensions, 2010.

¹⁷ <http://www.statistics.gov.uk/STATBASE/ssdataset.asp?vlnk=7403>.

Many people who receive AA or DLA will not be eligible for social care services because the threshold for social care services is set much higher and so fewer people are entitled to this type of support; or because they have a carer who is assessed as meeting their support needs (but not necessarily their extra costs). However even when someone is entitled to both AA/DLA and is assessed as needing personal care they generally do not get double support because the allowances paid is taken into account in the financial assessment for services.

Should AA and DLA be integrated with care services?

Age UK completed some very detailed analysis of the effect of integrating benefits and services under proposals for a National Care Service, put forward by the previous Government. We were very concerned that the financial advantages of a new funding system (at that time suggested models were Partnership and Comprehensive) would be more than outweighed by the future loss of entitlement to AA. Our main points were:

- It seems unlikely that a care assessment could assess need as consistently as the current AA system.
- A national entitlement could be replaced by support which could be more easily changed and may be cash limited, and this may involved more means-testing than the current system.
- It seemed likely that many older people would receive less help under the proposed 'partnership' model than from disability benefits. This is because all support above a minimum level will be means-tested. Additionally the proposed criteria for state support would have been unlikely to include all who would otherwise have been entitled to AA.
- The proposed partnership and comprehensive models would continue to take support from informal carers into account, whereas AA is awarded regardless of the availability of informal care.
- We were concerned that some of the additional costs of disability would not be covered under the new proposals.

For a care service entitlement to be equivalent to AA and DLA there would need to be:

- Clear and enforceable national guidelines around the assessment
- National training and monitoring for all staff carrying out assessments
- A consistent review and independent appeal system
- No strict limitations on the use of the money
- An entitlement to support based on need which is not cash-limited.

Many of the arguments made about the removal of Attendance Allowance and Disability Living Allowance remain pertinent. There was no clear evidence that the reforms would be beneficial, and in fact our analysis showed that many more people would lose out, both financially and because they would not receive care or a benefit of cash. If the Commission is considering the removal of these disability benefits there are clear tests of fairness, reach and effectiveness to be met. **Age UK would only support changes to the disability benefits system with firm guarantees about eligibility set down in law and if it clear that the reach and level of support of the improved system would be as wide as it is now.**

A key value for money issue the paper does not highlight is the tension between efficient procurement and the personalisation agenda. There is a contradiction in policy rhetoric here – on the one hand emphasising personalised services and individual purchase whilst on the other expecting efficiency savings. At the same time government is promoting multi-council commissioning and procurement *and* a reduction in the number of block contracts so that individuals can spot-purchase their own support with personal budgets. When cost saving rather than long term value is the priority both approaches are open to abuse, but in general we would expect cost pressures to rise faster under a personal budgets approach.

Examples of abuses:

- Personal budgets: some Local Authorities have tried to make savings by top-slicing the level of personal budgets, on the assumption that individuals can purchase more cheaply than the council, even though the Department of Health has said there is no clear evidence that this is the case.¹⁸
- Bulk purchasing: the recent use of reverse auctions for care services, especially by the NHS, has placed providers under undue pressure to sacrifice quality and all other considerations to put in bids at unsustainably low prices.

Finally, we think the Commission should consider the question of value for money from a personal as well as a system-wide perspective. One of the most frustrating things for older people accessing care services is that it is very difficult to identify the quality of service in advance. Price is often poorly correlated to quality of service, and this is especially difficult for self funders who may receive no additional guidance on which service will be best for them. In general people have little market power because decisions about care are made at a time of crisis and once settled in a care home it is extremely disruptive to move. Some of these barriers might be alleviated by system improvements, such as better information, but some are intrinsic as a result of the level of need of individuals. This imposes limitations on the effectiveness of the market in driving quality and cost effectiveness which need to be compensated for by regulation, stronger user rights, and individual and collective voice. This will provide more information to help people understand when paying more may be better value.

4. Awareness and complexity of current system – Age UK agrees with the Commission’s assessment of the complexity of the existing system. It is a severe impediment both to people who wish to plan ahead before needs becomes urgent, and to families needing to arrange care in an emergency. It is frequently impossible because information about entitlements is difficult to find, and vary widely according to geographic area.

A note on the observation in the paper ‘disability benefits are universal’ (p 17) we would like to remind the Commission that disability benefits are not universal but rather only available on the basis of disability-related need. Understanding entitlement can be as confusing as for the social care system itself, since not everyone with a disability would qualify for Attendance Allowance. The experience of Age UK services is that people who ‘self assess’ with respect to either disability benefits or social care often under-report need and are turned down for support they would be able to receive, if supported by a professional to accurately establish all their needs.

¹⁸ Use of Resources in Adult Social Care, Department of Health, 2009.

5. Perception of unfairness – we agree with the Commission’s summary of the various types of ‘unfairness’ in the social care system. To supplement the discussion, we would highlight:

- Risks in the shift to personal budgets – replacing commissioned services with personal budgets must be fair, so that people can secure equal outcomes whichever system is in use. Resources need to be adequate for providers to maintain high standards, employ reliable staff and provide high quality services.
- Non-financial support - considerations of the fairness with respect to income and wealth should take account of access to guidance, brokerage and information for self funders, as well as financial support.
- The role of legal entitlements - if due attention was given to individual rights and entitlements (including for self funders) many of the inequalities in access and provision would not be felt. There needs to be a consistent and clear framework of rights, which can be easily understood and which help the state, individuals and families to plan to meet future care needs. The Commission needs to work closely with the Law Commission undertaking the review of social care legislation, in order to make sure that this framework will be compatible with recommendations.

3. Given the problem we have articulated what are your suggestions for how the funding system should be reformed? How would these suggestions perform against our criteria that any system should be sustainable and resilient, fair, offer value for money, be easy to use and understand and offer choice? Please also take into account the impact that your suggestions will have on different groups.

Age UK believes that reform to the funding system should have the following characteristics:

1. **There has to be a broad consensus about the preferred funding solution.** Age UK believes that no new funding system will work unless there is settlement with respect to what is expected from care and support provision, how to access it, and how it is paid for. This is something akin to the pensions debate of the early-2000s which reached broad consensus which all parties could live with (despite no one achieving everything they wanted). It is essential that the Commission and the Government broker such a settlement. The state must not impose a new solution for funding care without ensuring that the public will 'buy in' to the proposal for increased financial contributions. Alongside this is the need for consensus within the political arena.
2. **Most people should see increased support under a new system.** Given high levels of existing unfairness and unmet need any reform should create many more winners than losers, so that almost everyone benefits. This will make it more likely that there will be public support for the changes and an understanding that increased contributions will lead to better service outcomes. In responding to last year's Green Paper proposals, Age UK set out detailed analysis showing that if disability benefits were withdrawn in exchange for improved care provision there would be a large number of net losers. For example most self-funders were expected to lose more in disability benefits than would gain from a co-payment under the partnership model.
3. **General taxation should continue to make a large and growing contribution to the costs of the care system.** Any reform should be based on a large continuing contribution from general taxation. For older people the starting point should be the £15 billion spent today on social care and disability benefits, with at least the equivalent proportion of GDP spent in future. We see this as the bare minimum of appropriate support from general taxation, predicated on other new sources of collective revenue being available as a supplement. If no other revenue streams become available spending from general taxation must rise as a share of GDP.

Proposals for any additional collective funding arrangements will need to be compatible with a continuing role for general taxation. The overall mix of funding streams will need to be judged on the basis of whether there would be (1) seamless integration at the point of need and (2) clarity with respect to the division of (uncertain) rising costs over time between different funding sources.

4. **New collective funding arrangements are essential to meet rising demand and pool some of the risks of care.** Even if care continues to be means-tested, additional revenue will be needed to expand provision to fulfil unmet need, adapt to demographic change and meet rising unit costs. This support will have to be found from general taxation, or other collective funding arrangements, regardless of any future reforms to provide a universal offer (see #5 below).

There are a number of ways that extra revenue could be raised, including general taxation, hypothecated social insurance and additional earmarked taxes. In recent years detailed proposals for a separate social insurance scheme for social care have been proposed. On balance, we are opposed to this option, although we would not stand in its way if this was the only viable means of securing new resources. Our concern is with the complexity of interactions within a partially tax-funded and partially insurance-funded system; and the lack of flexibility inherent in an insurance scheme, with respect to uncertainty in future need or cost. By contrast, we would support formal or informal earmarking of new sources of revenue that fell short of an independent insurance scheme, if this proves helpful in providing sustainable funding and public consent.

Age UK believes that the source of new revenue is a crucial decision, on which the acceptability of the whole reform package will depend. Any funding arrangements should meet the following criteria: (1) political and public consent; (2) affordability at the point of payment; (3) potential for growth over time; (4) fairness between generations; and (5) fairness between income groups.

In assessing different possible source of revenue we have come to the following conclusions:

- A system exclusively based on payment during working life is unlikely to meet the test of fairness between generations.
 - A system exclusively based on compulsory payment on death is intellectually coherent (as there is a clear link to uncertain costs near the end of life) but it will be challenging to secure political and public consent.
 - A system exclusively based on compulsory payment during or at the start of retirement is unlikely to meet the test of affordability at the point of payment.
 - Flat-rate payments, rather than contributions graduated according to personal resources, would not meet the test of fairness between income groups.
 - A system where contributions were linked to wealth is likely to meet the tests of growth over time; fairness between generations; and fairness between income groups. Detailed work is needed to establish schemes that would be affordable at the point of payment and secure political consent.
 - A number of small revenue streams rather than a single large one may make it easier to balance contributions across age groups and achieve affordability and political acceptability.
5. **A new universal offer, subject to affordability.** Our first priority is to establish a system which offers a sufficient quality and quantity of care for low income groups. But subject to affordability, we also support a universal financial offer to provide a degree of risk-pooling for everyone, including mid- and high-income groups. This will reduce everyone's exposure to the risk of needing care and tie everyone into a collective

system, which will greatly improve the take-up of care and the support available for decision making. We think any system needs to be compulsory to achieve universal reach (especially among mid income groups) and avoid to perverse interactions with the means-tested system.

The financial support could be one of, or a combination of:

- A flat-rate contribution (or tiered depending on level of need). This would be similar in design to free nursing care in England or free personal care in Scotland.
- Sliding contributions, with state support rising in line with personal contributions. This was one feature of the Wanless Review partnership model.
- Limited liability, with the state promising to meet all (or a very high proportion) of the costs of care, including accommodation, after a certain level of spending.

The value and design of the universal offer should be determined on the basis of (1) what is affordable to society; (2) what will prove sufficient to stimulate private consumption and eliminate unmet need; (3) and what will provide clarity to individuals and financial providers to enable people to choose to protect their remaining assets on a voluntary basis. We do not have sufficient analytical capability to make a firm recommendation on one option over the others, or to suggest a particular combination. However in principle we are attracted to a hybrid which offers modest support to everyone with care needs along with limited liability to protect against the highest costs.

We do not support options which would provide additional support to people who take out private insurance, as this would skew the distribution of resources towards high income groups (as is the case with pension tax relief).

6. **Development of financial products to support individuals to meet additional care costs.** If financial products were available that offered reasonable levels of cover for an affordable premium this might encourage more people to be proactive in planning to meet any future care costs. Although Age UK believes that voluntary insurance would not work as a solution in isolation, we support the development of pre-paid care insurance to provide a voluntary top-up to state financial support. To be effective insurers and customers would need total clarity with respect to what risk they were insuring – in other words what the state will and will not provide. People will need to be able to make a judgement based on a relatively accurate understanding of their potential future need for care, as well as what they might be liable for personally. The Government has a role to play in supporting the development and facilitation of this market. This includes a straightforward financial offer to enable insurers to develop products to meet outstanding gaps. In this context, a model featuring a limited liability component is attractive (this would cap the liability insurers would face for the 'long tail' of extremely expensive care, making products more affordable).

We also support the better promotion of financial products to meet care costs at the point of need. These include deferred payment schemes, equity release, and immediate needs annuities. These products are currently poorly promoted and little understood.

7. **Maintenance of payments to support people with the additional cost of disability.** Age UK strongly supports the role played by Attendance Allowance and Disability Living Allowance. These payments are very popular with older people and are used to support

additional travel expenses, laundry costs, heating costs etc. They ensure that moderately disabled people can remain independent and dignified. They also provide the only current form of support for people with high needs and high assets. Any reforms must retain their essential elements:

- A consistent assessment set down in legislation.
- AA/DLA should be a national entitlement which is not limited by cash available.
- The reach of disability benefits must be as broad as they are now, if they are subsumed into a care service the same people must benefit.
- AA/DLA are carer blind.
- Costs of disability still need to be met – there should be something available to people who are disabled to meet these additional needs.

The new system could retain disability benefits in their current form. Alternatively it could absorb them into a wider system of assessment and entitlement, as a basic payment intended to support people with disability-related living costs. However if proposals are put forward which affect AA or DLA there needs to be careful and accurate modelling in order to assess the full effects of any changes.

8. **National legal entitlements to outcomes, drawing existing systems together.** We support clear national entitlements, covering information, assessment and support arranging care for everyone. We also support a nationally consistent entitlement to financial support for people with low and moderate level needs who are currently ineligible for support in most areas (as well as a financial offer for mid and high income groups, subject to affordability – see #5). Additionally there is a case for integrating the administration and assessment of disability benefits, although this should not be used to undermine existing levels of entitlement.

We envisage a model on the following lines:

- Integrated, personalised and portable assessments of entitlement available to people of all incomes.
- Entitlement to support to meet outcomes through receipt of social care, so that providers and Local Authorities are bound to offer tailored support to help people meet these outcomes. The Department of Health has started to move towards measuring Local Authority performance against outcomes, which we support, provided there is adequate resource available to help people do achieve this.
- Everyone with needs giving rise to disability-related costs would receive a basic payment, equivalent to disability benefits today. This element should be available to people of all incomes.
- People who additionally meet a baseline level of eligibility should receive a personalised allocation of resources, determined on the basis of the support they need to meet nationally-determined acceptable outcomes. This allocation might not be paid in full to mid and high income groups (see #5).
- Allocations should be available as a single cash payment, but with the option of other formats, including professionally arranged support.
- The personalised payment should reflect variations in costs of securing identical outcomes in different parts of the country, but apart from this the system should be nationally consistent and transparent. The rate of payment should also see a fair return for care providers.

9. **Information, assessment, brokerage and advocacy services** need to be funded at a generous level, to ensure that all those accessing and arranging care services are able to put high quality care packages in place. These are essential 'transaction costs' of running an effective care and support system, and must be designed-in to the system's financing at the outset. This will benefit both those currently funded by Local Authorities, today's self funders, and carers. It will particularly benefit people who have no family or friends to advocate or manage affairs on their behalf.
10. **Complete age equality** is needed in the outcomes the system aims to achieve. This also relates to equality of access to funding, and equality in the use of existing personal funds to pay for care and support. The outcomes that someone should expect to be able to achieve with support should be the same, regardless of age.
11. **A reformed system should be 'carer neutral'** so that carers have a genuine choice about the extent to which they provide personal care, if at all. Assessments determining eligibility for care should cover questions on informal carers, but their contribution should not be taken for granted and it certainly should not be viewed as a necessity to fill in the gaps in the formal care system. Those choosing to care, particularly those giving up work to care, should be afforded a reasonable income as well as their own rights and entitlements to services. In particular, older carers should be taken into consideration when determining someone's need for care. The reformed system should not assume that all family are able to be carers, particularly when this is likely to have a negative impact on someone who may already be frail or have health problems. This should be factored in to all financial assumptions when considering new options for long term care funding.
12. **Seamless integration with the NHS and other public services.** There needs to be total clarity about the respective roles of the NHS and the care system. In our view this should include a greater role for the NHS in the provision of services closely linked to medical need (for example, personal care as well as rehabilitation in the weeks after hospital discharge). This applies also to the provision of medical care, nursing care and continuing healthcare in care homes where the NHS needs to take a greater role. More coordination between health and social care services could often reduce the need for expensive long term care, for example, by avoiding discharge from hospital into a permanent care home placement. With more careful rehabilitation and reablement, people should usually be able to return home with less intensive services.

In addition, population-wide or informally targeted preventative interventions should be commissioned jointly by health and local government, outside the auspices of a new financial system linked to legal entitlements. The role of the new Public Health service will be essential for ensuring that the need for care is avoided or delayed.

Housing services will continue to play a critical role in successful seamless service provision.

Low level housing support, including floating support services, assistance with repairs and maintenance and help with heating and insulation, will be financially constrained in the current economic climate. These services are a fundamental part of our ability to successfully deliver support services in the home environment. Evidence also demonstrates the cost effectiveness of low level housing support in allowing older people to avoid more expensive residential care or making unnecessary demands on

health and social care services. We believe that there should be the right to core housing support services (alongside core care services) that are universally available to all older people, preferably coordinated through the evolution of home improvement agencies.

- 13. The role of Local Authorities** will remain critical as the responsible body with oversight of key local functions. This should include a market shaping role, ensuring that their own commissioning or brokerage practices encourage smaller providers and innovative care solutions, and pay fair prices for care commissioned. They also have a critical role in providing information, assessments and support in arranging care. They will need to supervise the quality and safety of local provision and ensure safeguarding arrangements are in place.

In order to have a stake in good preventative services and an efficient local social care market, authorities should bear some of the costs of care and support. However a national system of entitlement and resource allocation should mainly be funded from a designated national budget, rather than through general local government spending.

- 14. No type of provision should be ruled out through implementation of a particular funding system.** All types of support should be available through the funding system chosen. The state must be able to support those people who would like services commissioned for them as well as those who prefer direct cash payments. This applies not just to care received at home, but also to use of and access to aids and adaptations, care home places, extra care housing and standard sheltered housing as well as new models of care in micro-providers, etc. It is particularly important that we achieve financial stability for retirement housing and the support options they are able to offer. It is important to ensure that retirement housing remains a realistic option for older people on low or moderate incomes whose costs are not covered by benefit payments. It is important that innovation can be supported as well, so that as new ideas are put forward they can be pursued without funding mechanisms causing unnecessary difficulties.

- 15. Increased faith in the solutions put forward by Government is needed.** Trust in future funding mechanisms will enable the Government to levy funds in a more flexible way, if the public are more reassured that those funds raised will be used for care. Lack of trust will increase the case for hypothecating revenue. However, what is gained by securing the funding specifically for care is lost by restricting the use of the funding, the possibility that what is raised is not enough, and preventing future Governments from using the money more efficiently. At Age UK listening events older people have told us that they are wary of additional taxes and levies being raised and then disappearing into a 'black hole' of general spending. But they are also sceptical about new independent institutions.¹⁹ Politicians will need to consider whether they can re-build trust, perhaps by recruiting credible independent experts to oversee the system, along similar lines to the Office of Budget Responsibility.

- 16. A permanent body is needed to take responsibility for ongoing analysis of demand and costs of care.** This body would report to the Government to advise whether revenue raising measures need to be altered due to changes in demand, unit

¹⁹ It's a heck of a gamble, isn't it', Age Concern, January 2009.

costs or other external factors. It could also establish an appropriate tariff of payments to individual social care users with different levels of need.

Devolution considerations

Age UK has partners in Scotland, Wales and Northern Ireland. Whilst we recognise that the remit of the Commission does not extend to these countries, any recommendations for reform will be watched closely, and will likely lead to changes, even if indirectly.

Our partners will make separate detailed submissions to the Commission, but we want to make the following points;

- In Northern Ireland the parity principle means that any changes to the tax and benefit system will have an impact on the administration of particular benefits. For example, if disability benefits were removed the devolved Governments would have the choice of continuing to operate the benefits or rolling up the benefit into its own social care provision. It is unclear whether the administrative costs associated with continuing to provide AA will be met by the UK government.
- In Scotland, whilst there is currently separate care legislation, there is common benefit legislation, so changes to underlying benefits would affect how social care is provided here.
- In Wales, there are particular issues which need to be considered in the Commission's recommendations. Wales has the highest proportion of older people (as well as the highest proportion of older people living with chronic conditions) and therefore it is very critical that care and support is available, high quality and is well funded. Age Cymru have done research which show that older people want a system funded through general taxation.
- There are also questions about how changes in the English social care system will impact upon block grant i.e. the Barnett Formula. There are a number of issues that will need serious consideration if this is recommended by the Dilnot Commission:
 - If the new system combined elements of disability benefits and social care spending how would this be treated in calculating block grant?
 - What would be the effects of separating out all or part of care and support spending into a separate fund?
 - What up-rating principles would be applied, and how would this effect block grant allocations?

Bringing these principles to life: Age UK's 'straw man' illustration

Overview

7. A single national system of legal and financial entitlements
8. An ongoing role for local government in assessment, support and shaping the care market, and responsibility for 20% of the costs of the system
9. State facilitation of financial products for voluntary top-up financing, including pre-paid insurance, immediate needs annuities, deferred payment and equity release.
10. Collective funding from general taxation and new compulsory payments (earmarked taxes, not a separate social insurance scheme)
11. Flexibility designed-in, with a national agency to review the effectiveness and cost of the system, and make proposals for overall budgets and scaling entitlements up or down.
12. Separate responsibility for the NHS for close-to-hospital care, and for local public services for commissioning early interventions and community-wide services.

Entitlements

6. Free NHS personal care and rehabilitation for 6 weeks following hospital discharge
7. Free integrated, personalised and portable assessments, stating outcomes to be achieved, carried out by councils
8. Free information and support to arrange care, available from councils
9. Free information and support for carers, available from councils, and a review of benefits for carers (aged above and below state pension age) in light of the reform package.
10. A single support payment, comprising
 - *For everyone whose disability gives rise to extra living costs*, a flat-rate payment, at no less than the lower rate for AA/DLA (non-means-tested)
 - *For everyone with support needs*, a personalised allocation of the resources required to meet assessed outcomes, on a means-tested basis (precise figures are illustrative)
 - *For the poorest*, 100% of resources to meet personal care and 80% of care home accommodation costs
 - *For the richest*, initially 50% of the resources to meet personal care costs and 0% of care home accommodation costs
 - *For the richest*, after £50,000 of expenditure incurred, 90% of resources to meet personal care and care home accommodation costs
 - The flat-rate payment would be uniform across the UK and carer-blind. The personal allocation would vary across the country to reflect variations in costs of securing identical outcomes, and take account of reasonable contributions from carers.
 - An independent agency would set a nationally consistent threshold for eligibility (comparable to FACS 'moderate needs'). It would undertake market analysis to set local payment tariffs, based on the resources required to provide high quality support that is sufficient to meet different levels of need, in different parts of the country.
 - Service users would be free to spend more or less than allocated. People who would face difficulties managing their own payments would have the option of alternative formats, including professionally arranged support.

Financing

5. General taxation would provide a fixed contribution to the system relative to GDP
6. Additional earmarked charges would be introduced at launch, to fund the shortfall between general taxation and the costs of the new entitlements. These would rise over time as this gap widened.
7. Earmarked charges could be a combination of the following: (a) the conversion of 'temporary' tax rises introduced to close the deficit into permanent care-related taxes from 2015 (eg ½ p on National Insurance); (b) the introduction of National Insurance for people over State Pension Age; (c) a modest levy on all inheritances and lifetime gifts; (d) a review of Capital Gains Tax and other wealth-related taxes
8. A national budget would meet 80% of costs with councils paying 20% to ensure they had an incentive to invest in prevention and appropriately assess eligibility. An offsetting reduction in local government formula grant, would lead to an increase in their financial autonomy.