FABIAN SOCIETY

A fresh start

Rethinking support and care for older people in England

Andrew Harrop

This paper was prepared for 'A New Agenda for Support and Wellbeing in Old Age' a summit on support and wellbeing for older people hosted by the Fabian Society. The society is very grateful to Age UK and Hanover Housing Association for supporting the whole project, including this research.

In preparing the paper the author spoke to a number of leading experts in the field and their input is very gratefully acknowledged: Caroline Abrahams (Age UK), Sir Andrew Dilnot, Lord Geoffrey Filkin (Centre for Ageing Better), Helena Herklots (Carers UK), Richard Humphries (King's Fund), Barbara Keeley MP, Tim Whittaker (Hanover). He would also like to thank some very special experts-by-experience in his own family.

Summary

Policy making on support and care for older people in England needs a fresh start. At the beginning of the parliamentary cycle and with government and opposition reviewing their policy, politicians on the left should think boldly from first principles.

This paper provides evidence, analysis and a proposed policy direction to help in that task. Its focus is the organisation and funding of support rather than the development of frontline practice. Its remit is support for older people, but solutions are also required for younger disabled people and new answers must work for both age-groups.

Silo-thinking has held back the search for solutions

The policy debate on older people with support needs is stuck because it is too narrow and fragmented. Most of the focus is on local government social care which comprises less than 30 per cent of the £25 billion of public spending identified in this study - which includes social security, housing support and a range of NHS services.

The role of carers and of self-paid and charitable support is often marginalised. The public offer to older people who need support will always have to work in partnership with family carers and private and charitable activity.

The state now helps older people who need support to meet their low-level needs and their high-level needs. Without any explicit debate or decision it has gradually withdrawn from supporting medium-level needs.

The government and opposition politicians now need to develop reforms and lead the system in a coordinated way across all these forms of support.

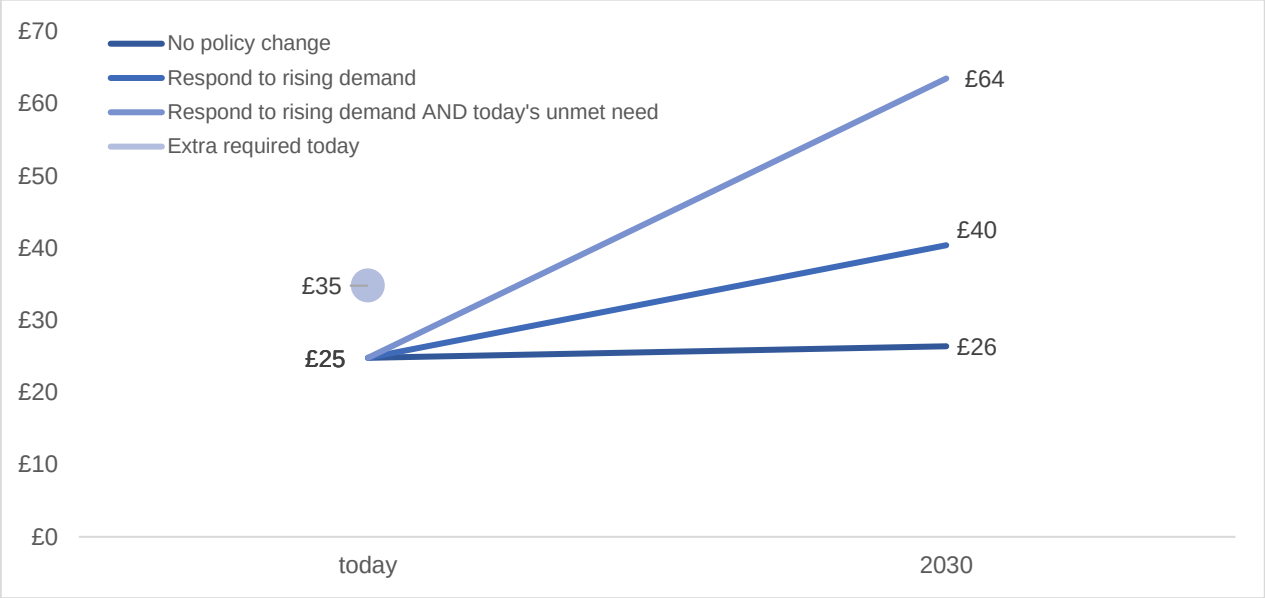
Spending must rise immediately and rapidly – whether or not new entitlements are introduced

Levels of disability in old age are rising fast. Our review of existing projections indicates that, just to maintain current levels of provision, public spending in England will need to rise from £25 billion now to £40 billion in 2030 – or from 1.2 per cent of GDP to 1.8 per cent. This is equivalent to an increase in real spending of 3.8 per cent each and every year. What's more, most of the projections are based on quite optimistic assumptions about older people's future health.

We estimate that £10 billion of extra public spending is required to fully meet present need. This includes: providing services to 1.2 million low-income older people currently without adequate support for essential daily tasks (£5 billion); extending NHS rehabilitation services to all who could benefit (£1.5 billion); adequate funding for care homes (£1.3 billion); and funding an expanded supply of supported housing (£0.9 billion).

To meet all these needs and also to keep up with rising demand might mean spending around £60 billion by 2030.

Summary of public spending scenarios for support and care for older people in England (£ billion, 2017/18 prices - see appendix 1 to 3)



An honest debate is needed about how to allocate extra money

The scale of rising demand means that even if a lot more public funding becomes available, there will be difficult trade-offs between: (1) appropriately funding the support already on offer, under current eligibility rules; (2) reducing unmet need by expanding the range of support available; (3) offering fairer funding to affluent older people; and (4) investing in the most cost-effective support.

A significant proportion of existing support is available universally, mainly via social security or NHS services. But social care is means-tested and there are good reasons for wanting to extend publicly-funded care to richer older people. But there are opportunity costs too and free social care for all may not be the right choice given competing calls for public money. The Care Act's 'cap' on lifetime spending should be introduced now, without ruling out other measures to further reduce means-testing in the future.

Housing-related services only account for 12 per cent of the public spending going to older people with support needs. Given the clear evidence of the cost-effectiveness of supported housing, equipment and adaptations this area should be a priority for extra spending.

The government has no obvious strategy for channelling capital investment into care homes, extra care housing or supported housing despite evidence that a huge expansion in capacity is needed. Over the next decade around 11,000 care home beds and 9,000 supported housing units for rent need to be delivered each year to keep up with projections of rising need. The planning system also places worrying constraints on development at the pace required.

Lots of new sources of revenue are needed not just one

Care and support should be funded in a wide variety of ways. First, rising receipts from existing taxes can pay for expenditure to rise in line with GDP. Second, broad-based progressive taxes can pay for spending to keep up with much of the rising demand (spending in this area should be no different to healthcare). Third, affluent older people should pay more taxes, especially to enhance the existing offer in a 'something for something' deal that improves the support available.

Raising taxes on affluent older people will be controversial, so is likely to be better achieved through a number of small tax increases on income and wealth, not one highly visible 'care tax'. These tax rises should be earmarked to earn public consent. This is separate from the question of whether

health and care should have truly ringfenced funding streams – which is a larger debate with good arguments on either side.

The machinery for funding public social care should be fundamentally re-wired

Adult social care (for all age groups) should no longer be funded from general local government funds. Today it comprises 33 per cent of this money but by 2030 the figure could rise to 46 per cent which is clearly unsustainable.

Three options should be considered instead (and they could be used side-by-side in different locations): (1) a designated grant to councils for adult social care, like the designated schools grant; (2) an integrated local budget for health and social care; (3) a single budget for all local public services in areas with high levels of devolution and robust democratic institutions.

A single budget for health and social care is probably the best option in most places to drive service integration and preventative investments. But commissioners must avoid creating new boundaries between health/care and other services, especially housing.

Social security and social care should be better aligned

Demand-led social security provides financial certainty to individuals. It also keeps the government honest by transparently exposing rising costs as more people become eligible for help. Benefits should therefore not be merged into cash-limited local budgets.

Disability benefits should be better integrated with social care, for example through combined assessment processes, advice for new claimants and regular screening of recipients' changing needs. But no end of improved integration can make up for the present hole in support for people with intermediate levels of need. There is now a clear gap in provision lying between disability benefits and social care.

Housing benefit and disability benefits should be paid to care home residents receiving public support. This would bring £2 billion extra funding into the system if paid in addition to present public spending. And even if the money was recouped by reducing grants, the policy would create a buoyant demand-led source of funding to respond to rising needs in the future.

Expanded public sector delivery should focus on fixing problems

There should be more direct public sector delivery but support and care should not be conceived as a public-only 'national service' like the NHS because family support and paid-for and charitable services will always exist alongside the public offer.

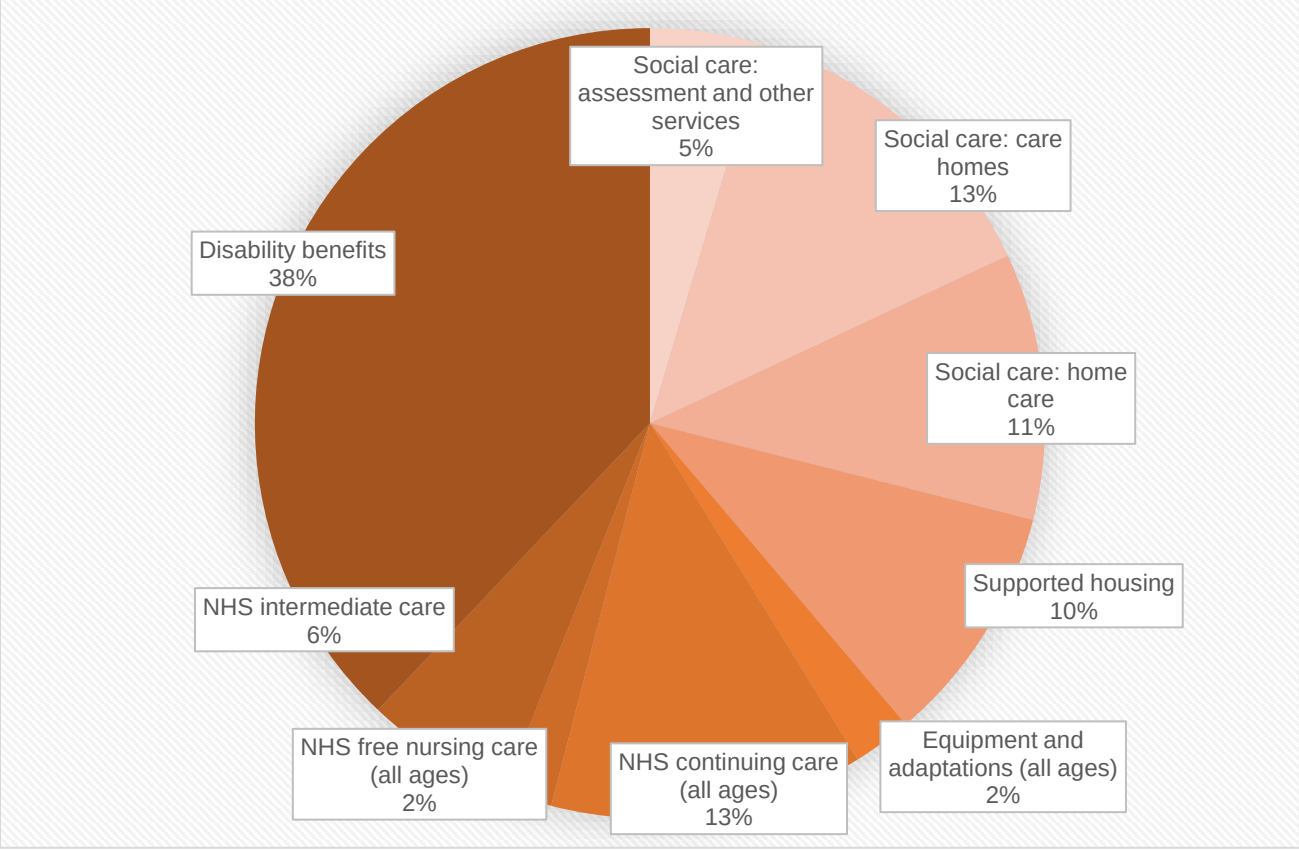
Moves to expand public sector delivery should be focused on fixing four problems, which the market-led approach to support and care are not addressing: (1) stepping in if or when providers fail (2) coordinating care for people with complex needs; (3) increasing capacity by investing in new care homes, extra care and supported housing; (4) providing care management for everyone.

1. Silo-thinking has held back the search for solutions

Public policy on support for older people has been 'stuck' for a long time. Yet there is nothing special about this issue to make policy-making harder here than in other areas where there has been significant recent progress - from pensions to climate change. Part of the problem is that perspectives have been narrow and fragmented, with an undue focus on local government social services. The premise of this project is that if we look at all forms of support together it becomes easier to see the 'big picture' and to find solutions.

Almost everyone who debates policy on the support and wellbeing of older people is guilty of silo-thinking, at least some of the time.* Notoriously, the media collapses debate on these issues into the question of whether an unlucky minority of wealthy older people should sell their homes to pay for care. But experts are guilty too. In particular, they often discuss state-commissioned/funded social care in isolation, rather than as part of a package of support that includes disability benefits, supported housing, equipment and adaptations as well as NHS services such as rehabilitation, nursing care and continuing healthcare. Figure 1 shows that social care comprises less than 30 per cent of public spending on this support. Appendix 1 sets out the data sources, the spending in each area and the number of people receiving support from each programme. This ranges from the 2.8 million who receive disability benefits to the 60,000 (of all ages) with NHS continuing care.

Figure 1: Social care comprises less than 30 per cent of the £25 billion pounds of annual public spending on older people with support needs in England



By looking at all the forms of support and all the funding pathways it is easier to understand the nature of existing failures and to design comprehensive solutions. For example a wide-angle view exposes how the part of the system which is failing to meet need the most - social care - is the

* This paper is guilty of silo-thinking itself – because it looks at older people only, when we need to design solutions that provide support and wellbeing for people with support and care needs of all ages. The trade-off with looking across service-silos has been to look at one client group only but any solutions must work for younger disabled people too.

responsibility of local government; while those elements funded via social security and the national NHS budget are doing much better. This suggests that getting the institutional wiring of the public sector right may be key.

Figure 1 also shows how most of the public spending is polarised between high-volume/low-needs support and low-volume/high-needs support. The former mainly comes through social security – ie disability benefits and housing benefit for supported housing. The latter is delivered through social care, NHS nursing care and NHS continuing care. In between there is very little provision for intermediate levels of need, with NHS intermediate care (ie rehabilitation) the only major programme. What's more, over recent years, the retrenchment of support has particularly focused on medium needs. Many fewer people are judged eligible for social care than before 2010 and traditional supported housing schemes are offering less intensive support than in the 1990s. Without any explicit debate or decision the state has withdrawn from supporting medium-level needs.

So far we've just been looking at public spending. But policy makers are also prone to forget that most support for older people is not commissioned/funded by the state at all. First, it is provided by friends and family (who offer direct care but also manage their loved-ones' affairs). If all this informal support had to be provided by paid-for services the costs would be extraordinary.[1] Second, older people buy their own support (partly with the help of disability benefits) from businesses, non-profit providers and individuals. This includes leasehold and rented supported housing, equipment, domestic help, gardening, repairs, care in the home and care homes. Third, charities and community groups provide a very wide range of support made possible by philanthropy and volunteering.

Informal, self-funded and charitable support is both positive and inevitable – the state should not be aiming to replace it but to provide complementary forms of support. Support for older people is therefore qualitatively different from healthcare or education, where a comprehensive public service addressing close to 100 per cent of need is in principle feasible and desirable. By contrast in this arena public policy needs to consider (1) how to create a positive partnership between the state-funded and other forms of support; and therefore (2) in what circumstances should state-funded support be in-cash not in-kind?

If we are to find solutions, the government and opposition parties will need to take the sort of holistic approach attempted in this paper. In developing proposals for reform and ongoing system-wide leadership the government needs to ensure a coherent, coordinated approach across the different forms of support. The creation of the Department of Health and Social Care could be a move forward in this respect, but only if new arrangements are introduced to ensure joint decision-making with departments responsible for housing, local government and social security.

2. Spending must rise immediately and rapidly – whether or not new entitlements are introduced

When policy makers discuss the 'ageing society' or 'demographic change' it sounds distant and theoretical, as if it is something we can postpone worrying about until never-ending austerity is over. Nothing could be further from the truth. Disability-related need is rising very rapidly, right now – as this year's NHS crisis is demonstrating. We need a new vocabulary to express this urgency.

The first call on new spending should be to adequately fund 'business as usual' as the number of older people with support needs grows. But in recent elections, politicians have failed to say this directly or to set out spending plans that provide adequately for maintaining the existing public offer. The temptation is always to propose new entitlements, before saying how much will be needed to pay for current provision as needs and costs rise. For example, in 2017 Labour pledged £3bn for

social care in England (for adults of all ages) but listed a range of new entitlements that much of this money would need to pay for.*

For this project the Fabian Society has reviewed a range of published estimates and projections for the rising costs of supporting older people over the next decade, on a business-as-usual basis. This is the first time projections across so many different areas of activity have been brought together in one place. Our conclusion is that, across all forms of provision, public spending on older people with support needs in England needs to rise from £25 billion today to at least **£40 billion in 2030.†** This is a rise from 1.2 per cent of GDP to 1.8 per cent of GDP, which is the equivalent of a tax increase in England of £7 billion today (the rest of the extra money would be generated by tax revenues rising in line with economic growth). The service-by-service breakdown is presented in figure 2 and the sources and assumptions behind each figure are set out in appendix 3.

Figure 2: Extra spending requirements for each service area by 2030 to respond to rising levels of need

	Billion
NHS continuing care (all ages)	£4.4
Social care: home care	£3.5
Social care: care homes	£2.4
NHS intermediate care	£1.5
Disability benefits	£1.2
Social care: assessment and other services	£1.0
Supported housing	£0.8
NHS free nursing care (all ages)	£0.5
Equipment and adaptations (all ages)	£0.2
TOTAL	**£15.6**

The scale of the spending required is illustrated vividly when put in terms of annual increases. To spend £40 billion by 2030, it will take an annual real increase of **3.8 per cent** – which will typically translate into a rise of **5 to 7 per cent** a year in cash terms.‡ Spending increases on this scale are needed this year and every year.

What's more these figures are relatively cautious. Most of the estimates take into account rising levels of disability (although worryingly this does not appear to be the case for the DWP's disability benefit projections). However, we've used variants based on relatively optimistic scenarios for population health: future health-related needs could be much higher if current health trends persist. This means that a significant focus on public health and preventative interventions will be needed even for spending on this scale to be sufficient.

The figures also assume that carers continue to provide the same proportion of care and support as they do today, which will require a very large increase in the amount of care provided by older people's partners, adult children and other relatives and friends. This might prove impossible for family and friends to supply.

* The 2017 Labour party manifesto said: 'In its first years, our service will require an additional £3 billion of public funds every year, enough to place a maximum limit on lifetime personal contributions to care costs, raise the asset threshold below which people are entitled to state support, and provide free end of life care.' In a separate costings document Labour promised to spend £2.1 billion extra, on the basis that this was the amount required to keep pace with rising demand and costs. It was never explained whether this figure was part of or additional to the £3 billion pledge.

† In some areas costings are only available for all adults but spending on older people is a very high proportion of the total.

‡ If GDP growth remains below the long-term trend of around 2.4 per cent over the next decade these figures will be slightly lower, since average earnings in the health and care sector will rise more slowly than is assumed in these projections.

These estimates are also based on existing patterns of service provision. In other words, they roll-forward the totally inadequate level of support seen today including the huge recent cuts in the numbers receiving home care, the inadequate size of many care packages, the under-funding of care homes and the under-supply of supported housing. For example, even though these spending increases are high, they would not provide enough money for commissioners to fully meet the ambitions (and legally binding obligations) of the Care Act's framework for assessment and eligibility. In other words, they do not take account of the extra spending that is already required now, to fully meet the needs of older people today.

To illustrate the scale of the challenge the Fabian Society has developed estimates of the extra spending required to fully meet the needs of older people requiring support today, under current financial entitlements. In total we estimate that **£10 billion** extra is required to meet present need, with a breakdown as follows (the sources and assumptions behind the figures are set out in appendix 2):*

- **£5 billion** – the cost of providing support to 1.2 million older people who aren't receiving help with essential daily tasks including washing, dressing and eating.
- **£1.5 billion** – the extra spending needed for NHS rehabilitation services to support all older people who could benefit.
- **£1.3 billion** – the cost of adequately funding council-paid care home places, to ensure sufficient quality and stop unfair cross-subsidies and top-up charges.
- **£1.2 billion** – a cautious estimate of the money to tackle isolation, promote wellbeing and step in early to prevent needs arising.
- **£0.9 billion** – a cautious estimate of the extra annual spending needed to bring the supply of specialist older people's housing more into line with other countries.

To increase spending over the next decade to both address these shortfalls and respond to rising demand would cost billions more. The Fabian Society estimate for the cost of meeting all need in 2030 is around **£60 billion**. This is 2.8 per cent of GDP. Increasing spending to this level would be equivalent to a tax rise of £24 billion today. In annual terms it is equivalent to a real rise in spending of 7.5 per cent a year (see appendix 3).

3. An honest debate is needed about how to allocate extra money

The extraordinary pace of rising demand means that even if significantly more public funding becomes available in the future, there will still be very difficult decisions to make. For every marginal pound of public spending there is likely to be a trade-off along the following lines:

EITHER **Appropriately funding support already on offer** to ensure quality and dignity for people who are entitled to help on the basis of current rules. This includes: no tightening of eligibility criteria; a skilled, fairly-rewarded workforce; provider payments that reflect realistic costs.

OR **Reducing levels of unmet need** for example by improving the support available to meet intermediate levels of need, supporting carers, or facilitating people to use their own money better.

OR **A fairer deal for affluent older people** for example those with very high lifetime needs so as to pool the risk of high care costs.

OR **A focus on cost-effectiveness** to make choices on the basis of what will deliver outcomes most efficiently, prevent further needs from arising and minimise costs across

* It is also likely that billions of pounds of disability benefits are not being claimed by older people who are eligible. The figure could be in the region of £10 billion but there are no accurate estimates for take-up. This number is not included in our estimates of the costs of unmet need, because disability benefits could in principle help meet other unmet needs identified in these costings.

the whole system (eg supported housing, equipment and adaptations; close-to-hospital services; wellbeing interventions and public health; new technology).

The current social care crisis demonstrates how hard these choices will be. Spending cuts have led to far fewer people receiving services; to the under-funding of domiciliary care which has led to exploitative workforce practices and inadequate packages of care; and to the setting of care home fees well below a sustainable long-term unit cost. Meanwhile community-based services aimed at supporting wellbeing and preventing isolation (which in the past were often available without a formal assessment of eligibility) are receiving less and less public support, even though they add hugely to quality of life and prevent future service needs. With so many challenges to address, it is not obvious how to divide each new pound of spending: all these calls for extra spending are pressing.

Moreover, the instincts of many on the left are to embrace universalism and provide more care and support entitlements for free on the same basis as the NHS.[*] There are good reasons to offer more public social care to affluent older people. But the discussion in the previous paragraph illustrates how any policy in this territory has significant opportunity costs. Even when it comes to providing more government support to affluent older people, there are competing priorities. These are evident from the rival conclusions of the three major reviews of care and support conducted over the last 15 years. The priority of the 2006 Wanless Social Care Review was to reduce unmet need, which led it to propose public match-funding from intermediate needs onwards to promote the take-up of support. The priority of the 2011 Dilnot Commission on Funding of Care and Support was 'horizontal' fairness among wealthy older people, which led it to propose a cap on lifetime costs to pool the risks of prolonged needs. And the priority of the 2014 Barker Review was for fairness between people with different health conditions and integration across health and social care, which led it to propose free social care for people once they had very high needs (with the *quid pro quo* of accommodation charges for care home residents entitled to NHS continuing care).

A reform to older people's social care in England that both relaxed eligibility criteria to meet intermediate level needs and offered free universal care would cost more than £8 billion now and rise in cost to over £14 billion in 2030. In an ideal world a government of the left might choose to raise taxes to pay for all of this, but we need to remember there will be other competing priorities for enhancing the welfare state (including spending on pensions and healthcare for older people which each need to increase as a percentage of GDP). A limited entitlement, such as a lifetime cap on care costs, is probably preferable to making an under-funded offer of free care for all, if this were to result in insufficient funding being available for older people with low incomes. So a partial offer to affluent older people – be that on the lines proposed by Wanless, Dilnot or Barker – should be the starting point. Appendix 4 sets out the costs of some of the recent proposals both today and in 2030. The cheapest option is the cap on lifetime spending legislated for in the Care Act. Politicians should commit to this now, without ruling out other measures to further reduce means-testing in the future.

Looking beyond social care, it is important that future decisions on how to spend each marginal extra pound are taken across service silos. Integration between health and care is very important. For example, the difference in the availability of 6 weeks of NHS reablement (provided widely) and long-term home care (very tightly rationed) is the result of the institutional boundary between the NHS and social care, not an evidence-based assessment of cost-effectiveness or need. Supported housing, equipment and adaptations must not be sidelined either. Housing related spending is often very cost effective because it sustains independence and prevents the need for more acute and expensive services. The recent report on older people's housing by the House of Commons

[*] In figure 1 we saw that a high proportion of older people's support already is provided on a universal basis (ie disability benefits, equipment and low-cost adaptations, NHS services). At the other end of the spectrum, supported housing is publicly funded on a mainly means-tested basis through housing benefit; home adaptations costing over £1,000 are delivered through means-tested loans. Neither scheme attracts controversy. In between comes social care, which is means-tested but where there is ongoing controversy and challenge.

communities and local government committee is just the latest to marshal the evidence and call for more expenditure in this area.[2] Yet today housing-related support only accounts for 12 per cent of the total public spending identified in figure 1, a percentage that will decline in the future if new spending simply follows rising acute demand. Planned choices are needed to ensure that preventative interventions (which include low-intensity community services as well as housing-related support) are not squeezed out by immediate pressures for extra high-needs support.

Similarly, careful thought needs to be given to capital investment. Recently the government has chosen to increase capital spending on adaptations through the Disabled Facilities Grant. But there is no obvious strategy for expanding the stock of care homes, extra care housing and supported housing.[*] Published projections suggest that around 11,000 more care home beds and 9,000 more supported housing units for rent need to be developed each year to keep up with rising levels of need (though the mix between the two could be adjusted, if there were more high-support extra care developments). The pace of growth in supported housing would need be even faster to increase the size of the sector towards the level seen in other Anglo-Saxon nations (perhaps 30,000 new homes per year) – see appendix 3.

The government's *de facto* strategy is for investment to be self-funded through the future flow of rents and fees. However, in the case of care homes the fees paid to operators are now too low for them to fund capital investment to expand or upgrade even though rising demand means we will need 50 per cent more beds in 2030 than in 2015.[3] Similarly, social landlords need financial certainty to invest in supported housing including extra care schemes. Their future revenue stream is a little more certain now that the government has confirmed that housing benefit will continue to fund eligible rents and service charges for supported housing. But the financial model for extra care schemes is particularly complex as they depend on funding from housing benefit, home care, local authority grants and user charges.

Note, that money is by no means the only barrier to developing the new capacity we need. The planning system is probably a more important obstacle, especially with respect to supported housing.

4. Lots of new sources of revenue are needed not just one

We've seen that policy makers will need to make the case for high and sustained spending increases for older people's care and support. This will require a transparent and coherent strategy for generating resources, as part of broader plans for raising the share of GDP raised in tax and spent on public services. A plan to increase spending could consist of three components:

1. **End austerity** - incredibly, spending on older people's social care has been falling as a percentage of GDP since 2010. There should be no debate about the need to raise expenditure in line with GDP every year. This money should come from existing taxes whose revenues should rise in line with economic growth. But for this to happen the Conservatives' fiscal plans would need to be abandoned because they assume at least 5 more years of cutting overall spending as a share of GDP.
2. **Progressive taxation for all** – the overall tax burden of the UK needs to rise in response to demographic change. Much of this new revenue should come from broad-based progressive taxes that are paid by us all, but raise the most from those with the highest incomes. Progressive taxes on income, earnings and profits are an essential act of redistribution across income groups and across the lifecycle. We take this for granted when it comes to funding the NHS and should not exclude other forms of support for older people from the same approach.
3. **An extra contribution from affluent older people** – Most of the people who in 2030 will need support and care as older people are already retired. If they are to receive a better offer from the

[*] Similarly, investment in technology is probably too unambitious. The government needs to consider how to promote both private and public investment in R&D and adoption of support-related technology. There has not been scope in this paper to consider the role of technology in improving services and potentially reducing the pace at which future costs will rise.

state than is available today, it is right that those older people who can afford to pay more do so (ie a 'something for something' deal). This is important because today older people are 'under-taxed' compared to people of working age. They also have a greater capacity to absorb tax rises at present.[*] In particular, any new universal entitlements that benefit affluent older people *must* be paid for by them since their rationale is 'horizontal' distribution *within* the cohort of the rich/old. The choice about how generous the universal offer should be will in part come down to how willing affluent older people are to pay more, in the context of a well-managed democratic debate.

These three approaches should be deployed in a balanced way. Ending austerity will generate funds for the first **2 per cent** of annual real spending increases; higher overall taxes might provide enough to respond to rising demand and pay for spending to rise by **4 per cent** per year (which is in line with the long-term trend for the NHS); and older people themselves should pay for the extra needed to improve the public offer, which might take real annual spending increases to perhaps **6 per cent** for the next decade.

Raising taxes on older people is an extremely controversial issue and it would make more sense to introduce a series of small changes rather than a single highly-visible charge like Labour's 2010 inheritance tax proposal, which was quickly dubbed a 'death tax'. There are a wide range of options, many of which are not exclusively targeted at older people but would raise revenue from them disproportionately.

Revenue raising targeting richer older people

Taxes on income

- Introduce national insurance on earnings after state pension age
- Introduce national insurance on occupational pensions, perhaps at a reduced rate
- Lower national insurance for employees to eliminate the existing 4 per cent NI contribution to the NHS and raise the basic rate of income tax by the same amount
- Reduce the income tax relief and national insurance relief on pensions for high earners and their employers
- Scrap income tax savings and investment allowances

Taxes on wealth

- Introduce a reformed property or land tax, that is proportionate to property values (with deferred payment agreements for the asset-rich/cash-poor)
- End or significantly reduce tax-free lump sums for private pensions
- Reform capital gains tax (eg stop writing off accrued gains at death)
- Reform inheritance tax (reduce exemptions/transfers, apply to lifetime gifts, turn into a receipts tax)
- Introduce a new 'care charge' on inheritances, with a low tax rate and low threshold

[*] **Capacity to pay more:** The average incomes of retirees have risen over the last decade while those of working-age households have not – older cohorts have also benefited most from rising asset prices. There is therefore potential to increase taxes without an absolute fall in living standards, at least on average.

Under-taxed at present: Previous Fabian Society research for Hanover (*A presumption of equality*¸ 2014*)* has shown how older people pay a smaller percentage of their income in taxes than working-age households with identical incomes (because pensioners do not pay national insurance on either earnings or income). They are also wealthier on average than younger age-groups and wealth is taxed far less than income.

There is also the question of whether these tax rises should be specifically earmarked for care and support. At present the left seems less bothered than the right with identifying specific new sources of revenue to match new spending commitments. It is politicians on the right who are currently leading the debate on designated 'health taxes' in the search for a way round their general hostility to tax rises. The left believes in the principle that general taxation should pay for good public services, and that therefore general taxes should rise to reflect rising need.[*] In this context, care and support for older people must be viewed as a core part of the welfare state – and the debate on its funding should not be seen as fundamentally different from those on how to pay for other vital public services. Policy makers must not fall into the trap of calling for all extra spending in this area to be funded by specific earmarked tax rises when this approach is not being pursued elsewhere.

Nevertheless, a degree of soft hypothecation is probably helpful and inevitable as a communication device to explain a 'something for something' deal to richer older people. It would help make the case for older people paying for a spending increase that would lead to an improved offer - ie for rises in excess of the 4 per cent a year referred to above. This call for soft hypothecation would follow in the footsteps of Gordon Brown's 2002 increase in national insurance to pay for a one-off jump in NHS spending (this policy was introduced following the recommendations of the Fabian Society's 2001 commission on tax and citizenship).

The case for 'hard hypothecation' is less clear-cut. Ring-fenced revenue creates complexity and inflexibility but it also has clear benefits. In the long-term hypothecated taxes and social insurance funds may be the best way to win public permission for spending 'European' levels of GDP on public services; and earmarked taxes also help create annually rising revenue streams that can help to prevent raids on the budgets of other less high-profile but equally important areas of spending. However, the question of hard hypothecation is a larger debate and it should not be confined just to the issue of support and care in old age.

5. The machinery for funding public social care should be fundamentally re-wired

There is a strong case for saying that the present crisis in adult social care is the result of the current funding model not the nature of the needs or services. Social care is not a direct responsibility of central government unlike the NHS; and it does not have a demand-led funding system, like disability benefits and supported housing. Instead care has to compete for funding from cash-strapped local authorities. And it is largely funded by council tax and business rate payers, the vast majority of whom do not benefit directly from its services and have limited capacity to pay above-inflation tax rises.

In the past, seeking to reform the funding pipework for social care might have seemed like a distraction. On this view all that mattered was to get more money to the frontline to improve entitlements and services: local government finance is a quagmire that will never be fundamentally reformed so any effort to change the institutional architecture for social care will run into the sand; it would be better to focus on workarounds like the Better Care Fund.

Today, however, we've reached the point where those arguments no longer hold water. Local government is desperate for a solution that delivers a balanced and sustainable financial model even if it means less responsibility or autonomy. And matters will only get worse over time. In 2015/16 adult social care (for all age groups) accounted for £14 billion of the £44 billion spent by

[*] The 2017 Labour manifesto presented tax and spending plans separately without saying which tax measure would fund each spending commitment. But social care was something of an exception with the party suggesting it favoured specific new taxes: 'We will seek consensus on a cross-party basis about how [the National Care Service] should be funded, with options including wealth taxes, an employer care contribution or a new social care levy'.

local government in England – **33 per cent**[*] [4] Looking to the future, if adult social care is to grow in line with rising needs - for younger disabled people and older people - then public expenditure will need to reach at least £27 billion by 2030. If council spending increases in line with projected GDP growth over the same period then adult care will amount to an estimated **46 per cent** of all spending at the end of the decade. This is totally unsustainable – especially when most local government revenue comes from council tax and business rates and social care is used by under 1½ per cent of the population.

Once you buy the case for institutional reform, there are three broad options for revising the funding mechanism for adult social care:

- A **designated grant** for adult social care, replicating the designated schools grant. The overall level and geographic distribution of funding would become the full responsibility of national government. This seems appropriate since the Care Act introduced national criteria for eligibility. But councils would retain responsibility for delivery of services and assessment of need. Spending could be expected to rise faster than under the present localised system due to the greater political scrutiny and the funding flexibility that would come with social care being a nationally-funded responsibility.

- An **integrated budget for health and social care** including adult social care, NHS services (and also public health). This would be a powerful driver for integration, accelerating the progress made in many localities to commission care and health together. It would help to ensure that fair and cost-effective decisions were made across existing silos. The argument against this approach is that resources might be sucked into high-cost acute healthcare, owing to the power of acute health providers in local health economies and 'medical' rather than 'social' mindset of health commissioners. There are also important concerns regarding local democratic oversight and questions about the extent to which elected councillors (or mayors) should be in control of decisions about the integrated budget.

- A **single budget for local public services** could be the ultimate destination in some places where local devolution is well advanced, following the model of block grants to the Scottish and Welsh governments. The most likely contender for this approach is Greater Manchester, but such radical reform is only likely in a handful of places over the next decade – especially as it would need to be accompanied by robust democratic institutions.

All three of these options have the potential to deliver more sustainable funding for social care than the current model. Indeed a 'one size fits all' approach is not necessarily needed. All councils could move to a designated grant and this could then be merged into larger pots in areas where there was the appetite and capacity. On balance the full integration of health and care funding probably holds the most promise, given how dysfunctional the boundary between NHS and social care services is at present. This is particularly the case with respect to commissioning community services such as the distinction between intermediate healthcare and domiciliary care discussed earlier. Single budgets could lead to more commissioning of low-intensity services where there was a clear evidence base to show that the investment would prevent acute need. Single budgets might also facilitate combined delivery, breaking down the established demarcation between the health and care workforce which is often arbitrary and has resulted in worse employment conditions, workforce development and professional standards in social care.[†]

It is important to note that any move to create a ring-fenced care or health/care budget risks creating new boundaries and service silos. In particular there is a risk in creating an artificial divide

[*] Excluding schools, housing revenue account, police and fire.

[†] The case for integrated budgets would be even stronger if there was alignment with respect to entitlements. For example, the Barker Commission's proposals would end the artificial distinction between NHS continuing care and social care for people with very high needs.

between social care on one side and universal community or housing-related services on the other. For example, it would be unhelpful to have a major institutional divide between funding for home care, rehabilitation and assistive equipment (all in the health/care 'bucket') and home adaptations, renewals and supported housing (all local government housing functions). This applies to strategies for spatial planning and the promotion of capital investment too. Planners need to promote significantly more supported accommodation for older people, given the health and wellbeing benefits. Artificial financial demarcations should not drive choices about the balance of this expansion between care homes, extra care housing or conventional supported housing.

6. Social security and social care should be better aligned

There is also a good case for reforming the role social security plays in providing care and support. The essential role of **disability benefits** has been proven in the years since austerity began. Unlike with social care, spending on social security is directly led by demand. This means that since 2010 disability benefit expenditure for older people has risen in real terms to reflect need. With social care restricted to fewer and fewer older people, for huge numbers disability benefits have been the only public entitlement available to pay for support and care.

Both social care and disability benefits have assessment processes and eligibility criteria but assessments for older people's disability benefits have been more consistent across time and place. This is because social security is demand-led and decision makers are not responsible for policing spending, unlike social care commissioners. It usually takes legislation to change how eligibility for social security is assessed, while in social care the practice of assessment seems to be in constant flux. Demand-led annually managed expenditure (AME) is unpopular within the Treasury, compared to fixed departmental budgets. But demand-led entitlements are really in the government's long-term interests because they transparently expose rising costs and the difficult policy choices these bring.

For this reason, disability benefits should not be merged into cash-limited local budgets, as was proposed by the 2014 Barker Commission and by DCLG in 2015 (following criticism the government has withdrawn this proposal).[5] However social security and local public services should be better integrated – through cross-referral, data-sharing or joint assessment – and the delivery of disability benefits could be reformed to ensure people use the money effectively. For example, a new claim for disability benefits could trigger an advice session with tips on how to effectively use the money, details of local services and referrals to other sources of support; or local health and care services could be required to regularly screen all benefit recipients to identify whether new support needs have emerged. The Strategic Society Centre has set out a variety of other good options.[*] However none of these ideas would resolve the problem of the absence of support for intermediate needs, in between disability benefits and social care. As things stand, many people who qualify for disability benefits would not be eligible for other support even if there was better integration of advice and assessment across the two systems.

Housing benefit is also demand-led and it provides over £2 billion of annual support for older people's supported housing in England. It provides long-term certainty to social landlords and in principle allows them to plan new developments with confidence. The value of this model was revealed by the government's recent proposals to reduce housing benefit for specialist housing and replace some of it with a cash-limited grant. This threw the business models of providers into doubt and led to the majority of planned development being delayed or cancelled.[6] Since then the government has listened to the sector and promised a new 'sheltered rent' rate of housing benefit,

[*] Proposals included: renaming the benefit 'independence allowance'; automatic 2-way signposting between DWP and social services; joint assessments for disability benefits and social care; disability benefits as the trigger for social care assessment and support; disability benefits as the trigger for information and advice; a joint brand for two separate entitlements; data-sharing between DWP and local authorities; nudge-based communication to promote independence enhancing ways of spending the money; soft-conditionality such as a twice-yearly compulsory phone call with an 'independence adviser'.

which will keep rents and service charges within the social security system. This climbdown is very welcome (although all the detail is yet to be announced). It means that the supported housing sector can grow to reflect demand, unconstrained by financial constraints (though sadly there are considerable non-financial constraints on expansion).

Publicly-supported **care home** residents receive far less social security than people living in the community. At present housing benefit is available to fund supported housing and extra care housing, but not care homes. Similarly, disability benefits are not payable to people receiving public support who live in a care home whereas they are for people living in supported housing and extra care housing. This stark divide seems increasingly inappropriate given that the aim of extra care models is to blur the line between care homes and supported housing.

The lack of social security in care homes is a hidden tax on social care commissioners, levied by a different arm of government. If these benefits were available to publicly-funded care home residents (and claimed in full) social security would contribute an extra £2 billion towards spending on care homes each year. By contrast in 2015 councils are estimated to have paid £3.2 billion in care home fees so this 'missing' contribution from social security makes up a very high share of their care home spending.[7] In the past the government could justify the withdrawal of social security on the grounds that the same money would reach residents via central government grants to councils. However, this argument no longer applies as these grants have almost disappeared and unrestricted local government expenditure is self-financing. Local authorities take on liabilities for people who were formerly funded in their homes by central government and receive no financial support in exchange. It is time for social security to take on more of the burden.

If this new social security spending was *added* to the existing resources available for support and care (without a parallel reduction in other revenue streams) it would significantly expand the total money available and would be a big step forward in addressing current underfunding. But even if at the outset extra social security spending only *replaced* social care funding pound-for-pound, the policy would still be beneficial. It would provide buoyant, demand-led revenue in the future, creating a more automatic and flexible response to rising need. Financial discipline would still be maintained however. Local commissioners with cash-limited budgets would still pay part of a care home's fee so the system would retain incentives for controlling costs and ensuring that each placement is appropriate.[*]

Figure 3: a partnership approach to funding care homes: typical weekly costs, 2017

	Residential care	Nursing care
Disability benefits	£83	£83
Contribution from other income (minimum)[†]	£97	£97
'Sheltered rent' housing benefit (estimate)[8]	£140	£140
NHS nursing care	-	£155
Social care (residual)	£347	£382
Benchmark cost[9]	£667	£857

The introduction of the new 'sheltered rent' creates an opportunity for reform because it places an upper limit on housing benefit payments. This new upper limit could now be applied to care homes as well as supported housing and form the first part of the state's contribution to their fees (ie a payment for care home accommodation). At the same time disability benefits could be made available as a tenure-blind universal contribution towards the costs of support and care. Figure 3

[*] In the 1980s housing benefit funded all care homes in independent care homes without local cost control.

[†] ie 50 per cent of pension credit for a couple, less personal expenses allowance.

shows how this would reduce social care commissioners' costs per resident by around £220 per week or £11,500 a year.*

7. Expanded public sector delivery should focus on fixing problems

Under the leadership of Jeremy Corbyn the Labour party is committed to an expanded role for direct public sector delivery, through nationalisation and insourcing. In January 2017 Corbyn announced in a speech to the Fabian Society that this approach could include the care home sector.† The Labour party has also at times suggested it wants only local authorities, and not housing associations, to build new social housing.[10]

The pattern of current provision is an accident of history. Healthcare is provided almost exclusively by the public sector. Supported housing is mainly delivered by non-profit housing associations. And social care is mainly delivered by for-profit companies. The pay, conditions, skills and career progression of the three sectors' workforces reflect this distinction and, whatever ownership models are used in the future, better commissioning and regulation is needed to improve working conditions and the quality of support across all providers.

There is also a good case for expanding direct public sector delivery. However increased government provision should be targeted at fixing genuine problems not wholesale nationalisation just for the sake of ideology. Policy makers should consider expanding direct public sector delivery in four contexts, linked to clear problems with the present system.

1. **Provider failure** – where independent operators are unable to sustain acceptable standards or their businesses fail entirely, commissioners should have local public sector providers, such as integrated health and care trusts, ready to step in. Even if the ownership of property assets remains in private hands, public providers should be able to take over as operators at short notice. In the case of care homes this could be challenging because in many localities there is no remaining public provision and the associated management and frontline expertise does not exist. All areas therefore need to make contingency plans in the event of the failure of a large care provider.

2. **Coordinated care** – integrated public sector service delivery may be suitable for people with complex needs that require a range of professionals and the expert coordination of care. In these circumstances a lead professional should have overall responsibility for coordinating the person's support and everyone involved should regularly review the individual's needs together. These functions are likely to be discharged better when all the providers are public sector ideally with much of the delivery in the hands of a single provider that can blend health and social care. This approach could lead to the commissioning of combined health and care trusts with in-sourced domiciliary care for people with the highest needs.

3. **New capacity** – as we have seen, the government appears to have no plans for expanding the capacity of care homes, extra care schemes and supported housing even though all these sectors need to grow hugely over the next decade. The present model assumes that new units will be developed by independent operators, with self-funded investment. But as we have seen, social care commissioners are not providing the financial certainty to invest. Given the scale and

* If any form of free care is introduced for affluent older people, these figures could also be used to set the level of the contribution required from residents towards the care home costs ie £83 + £97 + £140 = £320 per week. The same approach could be taken with respect to NHS continuing care, as the NHS's current funding for long-term accommodation and living costs in care homes is difficult to justify.

† 'a Labour Government would give social care the funding it needs and give a firm commitment to take failed private care homes into public ownership to maintain social care protection', speech by Jeremy Corbyn MP to Fabian New Year conference, 14 January 2017.

urgency of the requirement for additional capacity there is a strong case for the public sector taking on a development function in the care home and supported housing markets, using public investment. Given how much new capacity is needed (and that the public sector would begin development from a standing start) it would be sensible to promote this new programme as a supplement not a substitute for development by housing associations and care operators.

4. **Care management** – the Care Act gives everyone who has eligible needs the right to ask for a local authority to arrange their care. This right is not being widely promoted and many local authorities place barriers in the way of people having assessments in the first place. Social care commissioners should in future play a much larger role in supporting everyone with support needs to secure suitable services, since securing effective community support or choosing a care home is a huge challenge whatever someone's financial resources. With sufficient resources commissioners could work on the presumption that care management is 'opt out' not 'opt in' when they are contacted by people seeking help and then develop specialist advice and brokering services. Take-up of the right to care management will also be enhanced if the 'cap' legislated for in the Care Act is introduced, because people in all financial circumstances will need to undergo assessments in order to 'start the taxi meter' for the cap on lifetime charges (the requirement for everyone to be assessed can be considered a positive feature of the Dilnot reforms, even though it adds to the costs of the system). Ideally the right to care management should be available even for people who are not currently deemed to have sufficient needs to be eligible for publicly funded services.

Public sector bodies should also lead and coordinate the work of independent providers. Non-public sector partners (eg housing associations, local charities and reputable care homes) should be expected to fully participate in the coordination of care and operate with a clear public ethos and character. This implies a long-term strategic relationship with public commissioners and providers, working in networks of professional collaboration. The Fabian Society's 2014 report *Going Public* discusses many of these issues, looking across public services in general.

However, it would be a mistake to view the endpoint as a completely nationalised public care service. This is because older people will always receive support and care from informal carers and from paid-for and charitable services as well as from publicly-funded provision. Indeed, the government explicitly encourages this through the payment of carer's allowance and disability benefits. So public policy should seek to preserve a mix of provision that goes with the grain of people's lives. On the one hand, we should be suspicious of attempts to reduce the scope of public service delivery, such as proposals for the widespread use of personal budgets in health and care (these are market interventions not public services). But on the other hand, we should reject a purely public sector institution if it means that the boundaries between different forms of support and types of provision become less flexible.[*]

Any reform needs to ensure that rich and poor receive services side-by-side. The aim should be to ensure excellent outcomes for people from all backgrounds, whatever their income. In healthcare this is best achieved through a universal publicly-delivered national service. But in other areas of care and support this is best achieved by a mix of providers and a blend of in-kind and in-cash public support. There is a parallel with early years provision, where there is a good case for supporting state-delivered children's centres *and* high-quality registered childminders. If the public sector offer is too rigid, it will lead to affluent older people opting-out: public provision must mesh easily with the additional support they will always chose to buy.

[*] For example, if personal care was always delivered by a public employee would a user be able to pay extra if they wanted their care worker to do a few hours extra each week cleaning, gardening or running errands? Would a self-funding care home resident whose resources ran out have to move from a private to a public care home, with all the health risks that the transfer might entail? Would extra care housing schemes be able to operate as mixed communities with social tenants and leaseholders living side-by-side?

Additionally, and more prosaically, nationalising all providers of care and support would be time-consuming and very expensive. In particular, it would cost many billions of pounds for the government to buy the existing stock of care homes and supported housing. The government or local commissioners should have the capacity and expertise to step-in quickly in the event of service failure, but the public sector should not routinely seek to take over services where providers are delivering to acceptable standards.

Appendix 1: Today's public spending on provision for older people with support needs (England, 2017/18 prices)

	Number of recipients	£ Billion	% of GDP	Note
Social care: assessment and other services	-	£1.1	0.1%	1
Social care: care homes	170,000	£3.3	0.2%	1
Social care: home care	260,000	£2.7	0.2%	1
Supported housing	450,000	£2.4	0.1%	2
Equipment and adaptations (all ages)	40,000*	£0.6	0.0%	3
NHS continuing care (all ages)	60,000	£3.2	0.2%	4
NHS free nursing care (all ages)	60,000	£0.5	0.0%	4
NHS intermediate care	1,300,000*	£1.5	0.1%	5
Disability benefits	2,800,000	£9.4	0.5%	6
TOTAL		**£24.8**	**1.4%**	
Note: Private spending on social care (net of disability benefits)		£9	0.5%	1
Note: Other NHS care for over 65s (approximate)		£41	2.3%	7
Note: Other social security for pensioners		£89	5.1%	6

Notes

* For these services this is the total number supported each year (a flow measure). Other estimates for recipient numbers look at a snapshot of the number supported at any one time (a stock measure).

(1) PSSRU 2015/16 data.[11]
(2) DWP/DCLG 2015/16 estimates.[12] Note, supported housing is defined as social rented housing, so excludes owner-occupied housing in developments operated by social or private landlords.
(3) DCLG 2017/18 data – equipment[13], disability facilities grant.[14] The number of recipients is the annual number benefiting from major works under the disability facilities grant (though the benefits of the adaptation can be expected to last for more than one year).
(4) NHS England 2015/16 data.[15]
(5) NHS Benchmarking 2016/17 data.[16]
(6) DWP 2017/18 projection.[17]
(7) Fabian Society estimate derived from 2016/17 data. Estimate based on NHS England budget less local government Better Care Fund expenditure; multiplied by share of NHS resources used by people aged over 65 (resource use profile for 2021, *Fiscal Sustainability Report*, OBR, 2017); less spending on continuing care, free nursing care, intermediate care reported elsewhere in the table.

Appendix 2: Estimated extra spending required to fully meet the needs of older people today, current financial entitlements (England, 2017/18 prices)

	£ Billion	% of GDP	Note
Social care: wellbeing	£1.2	0.1%	1
Social care: care homes	£1.3	0.1%	2
Social care: home care	£5.0	0.3%	3
Supported housing	£0.9	0.1%	4
Equipment and adaptations (all ages)	£0.1	0.0%	5
NHS continuing care (all ages)	-	-	6
NHS free nursing care (all ages)	-	-	6
NHS intermediate care	£1.5	0.1%	7
Disability benefits	[£9.4]	[0.5%]	8
TOTAL (excluding disability benefits)	**£10.0**	0.6%	

Notes

(1) The conservative costs of meeting the 'wellbeing' needs of older people (eg isolation), drawing on projections for 2012 and 2022 by the Kings Fund, prepared for the 2006 Wanless Review.[18]
(2) The difference between average local government care home fees and average costs of service provision.[19]
(3) An estimate of the cost of providing support for older people with difficulties in carrying out essential activities of daily living (ADLs) who do not obtain the amount of support they need from carers or services, and who are eligible for help under present means-testing rules.[20]
(4) A cautious estimate of the extra annual spending needed to bring the supply of specialist older people's housing more into line with other countries. The provision of retirement and extra-care housing is very low in England compared to other Anglo-Saxon countries. This Fabian Society calculation is based on an industry estimate that the market could grow by 500,000 units (ie nearly double in size).[21] We assume around 200,000 units are funded by housing benefit (with more than half of these tenants assumed to be previous housing benefit recipients in general needs housing).[22]
(5) The cost of bringing forward government plans for Disabled Facility Grant spending for 2019 (spending is doubling over 5 years to reach a scale that is likely to be much more reflective of need). No evidence identified on unmet demand for equipment.
(6) No evidence identified on levels of unmet need. However, the National Audit Office has found wide variation in patterns of spending that suggests national eligibility criteria are not being consistently applied[23]
(7) A 2012 NHS audit estimated that capacity needed to double to meet demand from all who could benefit.[24] There has been no commensurate increase in provision since then.
(8) There are no recent estimates of take-up of disability benefits. A 1998 study estimated take-up of around half those eligible, although a later study demonstrated weaknesses in the methodology. Due to high uncertainty unmet need for disability benefits is not included in the overall estimate. It is also likely that higher disability benefit payments would reduce need for other services (eg home care and wellbeing-related support). [25]

Note, all these needs are conceptually different but there is likely to be some limited overlap between the categories (eg home care to meet support needs, intermediate care to prevent acute health incidents). In a wider range of instances meeting unmet needs in one area is likely to reduce need in another over the medium term (eg 'wellbeing' services and supported housing will reduce demand for acute NHS and social care services).

Appendix 3: Scenarios for public spending on older people with support needs in 2030, current financial entitlements (England, 2017/18 prices)

	A. No policy change (eg inflation increases)		B. Respond to rising demand		C. Respond to rising demand & today's unmet need		Note
	£ Billion	% of GDP	£ Billion	% of GDP	£ Billion	% of GDP	
Social care: assessment and other services	£1.1	0.1%	£2.2	0.1%	£4.4	0.2%	1
Social care: care homes	£3.3	0.1%	£5.7	0.3%	£8.0	0.4%	1
Social care: home care	£2.7	0.1%	£6.2	0.3%	£17.6	0.8%	1
Supported housing	£2.7	0.1%	£3.3	0.1%	£5.4	0.2%	2
Equipment and adaptations (all ages)	£0.6	0.0%	£0.8	0.0%	£0.9	0.0%	3
NHS continuing care (all ages)	£3.2	0.1%	£7.6	0.3%	£7.6	0.3%	4
NHS free nursing care (all ages)	£0.8	0.0%	£1.0	0.0%	£1.0	0.0%	5
NHS intermediate care	£1.5	0.1%	£3.0	0.1%	£6.0	0.3%	6
Disability benefits	£10.5	0.5%	£10.5	0.5%	£12.5	0.6%	7
TOTAL	**£26.4**	**1.2%**	**£40.4**	**1.8%**	**£63.5**	**2.8%**	

Notes: These estimates were developed using published projections of spending increases. Where an estimate was not available we assumed growth would be at the same rate as for services serving similar client groups. Projections to 2030 were not available in all areas so the Fabian Society calculated annual percentage increases over the span of each projection and assumed that spending would continue to grow at the same annual rate through to 2030.

(1) Scenario A assumes constant real spending to reflect spending decisions since 2010. This will lead to a significant reduction in the numbers receiving social care (let alone the percentage of people with care needs). Scenario B uses PSSRU projections based on demographic shifts and an assumption that real unit costs rise by 2.2 per cent per year, which is in line with OBR long-term expectations for average earnings. This results in a 4.4 per cent real annual increase in spending on assessment and other services; a 3.7 per cent real annual increase in care home spending; and a 5.7 per cent real annual increase in spending on home care and direct payments. No extra allowance is made for implementation of the National Living Wage as there is no evidence this has led real unit costs to rise faster than 2.2 per cent. Scenario C applies the same annual increases but uses a baseline that combines current spending with our estimate for unmet need. A PSSRU sensitivity analysis suggests these projections may be conservative, with demand likely to rise even faster, given current trends in disability. [26]

(2) Scenario A assumes the existing rate of development of rented supported housing, of around 3000 new units per year. Housing Benefit spending rises to fund the percentage of new tenants who are eligible. Housing benefit rates and non-social security support is constant in real terms. Scenario B again assumes unit costs rise in line with inflation. The number of units rise to reflect demand, based on PSSRU projections for demographic shifts (which leads to a 2 per cent real annual spending increase). This requires a significant increase in the supply of new rented homes, with stock increasing from 395,000 in 2015 to 535,000 in 2030 – a net increase of over 9,000 units a year. Scenario C uses the same growth projections but applies a baseline combining current provision and the previous estimate for unmet need. The stock of supported rental units more than doubles from 395,000 to 875,000 – which requires an implausible net increase of over 30,000 units a year. These estimates are for revenue costs only (implying capital investment is self-funded).[27]

(3) Scenario A assumes no real change in spending; Scenario B assumes costs rise in line with PSSRU projections for demand for rented supported housing, as the client groups are likely to be similar (ie 2 per cent annual real increase). This is likely to be a conservative estimate as labour costs for adaptations will rise faster than inflation. Scenario C uses the same projections but applies a baseline combining current spending and unmet need.

(4) Scenario A assumes no real change in spending (implying tighter eligibility criteria); Scenarios B and C assume costs rise in line with NHS England projections for 2015/16 to 2020/21 (ie 6 per cent annual real increase).

(5) Scenario A assumes spending rises to reflect PSSRU projections for the rising number of care home residents, as this is a demand-led entitlement, but with constant real unit costs; Scenarios B and C also take account of rising unit costs (leading to a 5.1 per cent real annual increase in spending).

(6) Scenario A assumes no real change in spending. Scenario B assumes intermediate care costs rise in line with PSSRU projections for public and private spending on community care, on the assumption that the intermediate care serves a similar client group and has similar unit cost inflation (ie 5.7 per cent real annual increase). Scenario C applies the same projections but uses a baseline combining current spending and unmet need.

(7) Scenarios A and B report DWP projections, applying current uprating rules (ie inflation only) which leads to real spending rising by a 0.9 per cent per year. Scenario C reports DWP projections, but based on the OBR assumption that disability benefits will rise with earnings after 2021/22 (Scenario C does not assume a rise in take-up of disability benefits). The caseload projections underlying these forecasts appear conservative, compared to the future profile of disability modelled by PSSRU, implying tougher eligibility criteria or a decline in take-up by eligible older people.

Appendix 4: Estimated cost of options for reforming social care eligibility rules for older people, today and in 2030 (England, 2017/18 prices)

	2017/18		2030/31 (today's prices)		Note
	£ Billion	% of GDP	£ Billion	% of GDP	
Cap and better means-test (Care Act)	£1.3	0.1%	£2.2	0.1%	1
Cap and better means-test (Dilnot report)	£2.1	0.1%	£3.7	0.2%	1
Today's means-test, wider eligibility	£4.0	0.2%	£6.8	0.3%	2
Free personal care, today's eligibility	£3.5	0.2%	£7.0	0.3%	3
Free personal care, wider eligibility	£8.5	0.5%	£15.1	0.7%	3
Less: means-tested CHC 'hotel costs'	*-£0.3*	*-0.0%*	*-£0.7*	*-0.0%*	*4*

Notes

1. 2013 estimates.[28]
2. 2010 estimates (costs may be higher today, as eligibility has tightened in most areas since 2010).[29]
3. 2014 estimates.[30]
4. Fabian Society estimate, based on Dilnot Commission proposals for 'hotel' costs and the units costs of NHS continuing care. Assumes that half of residents not eligible for means-tested support.[31]

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