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Paying for social care

Beyond Dilnot



Key messages

- Successive governments have tried hard to find a more sustainable and fairer way of funding adult social care but with limited success. There has not always been clarity about the questions to which funding reform is the answer. The government's decision to implement the proposals of the Dilnot Commission, now incorporated in the Care Bill currently before parliament, is a significant stepping stone to wider reform, but will not on its own solve the social care funding challenge.
- Who pays for what across health and social care is confusing and incoherent. Reform has been made harder because of the fragmented way the social care system has evolved, leaving a system that is criss-crossed with fault lines between NHS and local authority social care, private and public funding, and private and public delivery.
- The government's proposals for funding reform are an important achievement against the odds in a daunting fiscal and economic climate. They establish a symbolic policy milestone – that the government should place a limit on how much people have to pay: the NHS has always offered protection from catastrophic costs in relation to health care, and these extend the same protection to social care. The proposals also make it easier for people to plan ahead.
- The combination of a cap on care costs and an extended means test will see more people benefit from public funding. Although the cap is slightly higher than originally proposed by the Dilnot Commission, future governments have the option of lowering it to increase coverage as fiscal circumstances improve.
- But implementation of the reforms will be challenging, with high risks of confusion, complexity and complaints; it will involve new roles and substantial extra work for local authorities when they are facing the most severe financial challenge in their history. Without a major and sustained public relations and awareness campaign, there is a real danger that many will see the reforms as a worse alternative to what they perceive as existing now, not as an improvement to the current system.

- In the meantime, local authority spending is continuing to fall and fewer people are getting help despite demographic trends. There are growing concerns about rising levels of unmet need, the impact on carers – exacerbated by the welfare reform changes – and the cumulative pressures these will place on the NHS.
- Attention should now focus on the aspects of care funding that were excluded from the Dilnot Commission's terms of reference and so are not addressed in the government's proposals. The central challenge is to assess the total quantity of resources needed to ensure that people have access to the right level of support, currently limited in most places to people with substantial or critical needs. For many people it is eligibility for help, not protection from costs, that is the primary issue. This is especially the case for adults of working age with care and support needs arising from disability and chronic health conditions.
- Building on the Dilnot framework, there are four key priorities for attention that could form the basis of a roadmap for social care reform.
 - The government and local authorities should ensure that robust and detailed preparation and planning arrangements are in place for implementing the Dilnot proposals, thus establishing a new framework for planning and cost-sharing.
 - Rather than raiding the NHS budget to bail out social care – ‘robbing Peter to pay Paul’ - the 2015/16 Spending Review should be used to move towards a single strategic budget settlement for the NHS and adult social care and closer alignment of local authority and clinical commissioning group (CCG) budgets around individual needs.
 - Health and wellbeing boards should play a key leadership role in ensuring that care reform is part of a wider transformation of local health and care services, alongside public health strategies to promote wellbeing and reduce future demand for health and care services.
 - There needs to be fresh debate about the options for funding the quantity and quality of care we will demand in the future and about ways of overcoming the dividing lines between how health care and social care are paid for. With this in mind, The King's Fund will shortly announce a fundamental review of the way that health and social care entitlements, benefits and funding are organised.

Introduction and background

The government's recent announcement to introduce a new funding model for adult social care, based on the recommendations of the Dilnot Commission, is the latest development in the long history of many attempts to review the way in which social care is funded and how the costs of these services are shared between the individual and the state.

But while the government's announcement has generally been welcomed by charities, local government and care providers as a step forward, there is general agreement that the number of people who will be helped by the new arrangements is limited and the pressures on the existing system are growing. There are four major reasons why the Dilnot reforms should therefore be seen as a staging post, not the final destination.

- The government's reforms will not be introduced until 2016; meanwhile, pressures on the current system are growing, as our recent quarterly monitoring report has shown (Appleby *et al* 2013). Local authority spending on social care has fallen for four years in succession, and fewer people are using publicly funded care than ever before (Local Government Association (LGA) 2013). With 87 per cent of local authorities setting their eligibility criteria at substantial or higher, it has become much harder for people to access care, especially if they have moderate needs. The human costs of a creaking

care system – in terms of pressure on carers, unmet needs and loss of independence and quality of life – are well documented (Care and Support Alliance 2010).

- Demographic and social trends show that need and demand for social care will continue to grow. This is not just about older people with multiple illness but also about rising numbers of working-age people with disabilities and long-term health conditions. This will test traditional demarcations between health and social care and the different ways in which these services are organised, delivered and funded when there is no prospect of real-terms budget growth.
- The current model of health and social care is skewed towards delivering episodes of acute health care in hospitals or providing permanent care in residential and nursing homes. But increasing numbers of people with long-term conditions, frailty and multiple illness will need longer-term support that is closer to home, promotes independence and self-care and is well co-ordinated across different services and professionals. This calls for an entirely different model of care in which social care, NHS and other resources are much more integrated around the needs of the individual. Greater priority will need to be given to reducing demand for formal services by promoting independence, boosting community capacity and promoting recovery and re-ablement. The implication of this is that future social care funding needs cannot be established simply through projections of existing costs.
- There is growing concern about the quality of care in hospitals, care homes and people's own homes. Experiences at Winterbourne View and Mid Staffordshire Hospital have shaken beliefs that most care is good and imply there may be wider systemic issues. The relationship between quality and resources is not straightforward; tightening budgets are starting to raise difficult issues about how the quality of care can be protected and improved when commissioners and providers are under severe financial pressure and face trade-offs between quality and access to care.

Now that the government response to Dilnot is clear, it is time to step back and take stock of what the proposals will mean in the context of the overall challenges facing the whole system of health, care and support over the next decade and beyond.

So the purpose of this paper is to:

- set out the recent history of attempts to reform social care funding
- offer a brief analysis of trends in social care and of the consequences for how it is funded
- assess the progress made by the coalition government and the likely impact of its proposals
- consider options for how we fund care in the future and propose four key priorities that could shape the next stages of social care reform.

A short history of social care reform

The current funding system for care and support originates in the 1948 National Assistance Act and the decision that what we now describe as social care should be provided through local authorities and should be subject to means testing, unlike NHS services, which would be free at the point of use. This approach has become increasingly unsustainable in the face of demographic change, rising affluence and changing patterns of illness that see the distinction between NHS and social care responsibilities blurred.

Successive governments have responded in a variety of ways, including better joint planning and co-ordination in the 1970s and 1980s, and attempts to contain costs and promote care at home through the 1990 community reforms (driven by runaway social security spending on residential care placements, where the issue was that too much was being spent, not too little). Since the late 1990s, attention has turned to the way care

Table 1 Reform initiatives since 1996

Year	Initiative
1996	Government launches consultation on 'A new partnership for care in old age'.
1997	'I don't want [our children] brought up in a country where the only way pensioners can get long-term care is by selling their home.' (Tony Blair, addressing Labour Party Conference) Royal Commission on Long Term Care appointed.
1999	<i>With Respect to Old Age</i> , Report of the Royal Commission on Long Term Care (Sutherland Report), published.
2000	Government's response to Royal Commission rejects proposal for free personal care but agrees to amend means test, introduce free NHS nursing care in care homes and invest in new services.
2002	HM Treasury commissions Sir Derek Wanless to conduct independent review of NHS spending. He recommends a more thorough assessment of social care funding needs but this is not acted on.
2005	Green Paper <i>Independence, Wellbeing and Choice</i> sets out new vision for adult social care based on independence, choice and control. Changes 'will need to be met from existing funds' over next 10-15 years. Sir Derek Wanless leads review of future social care spending needs for The King's Fund. <i>Securing Good Care for Older People</i> is published in 2006 and recommends partnership funding model.
2006	Joseph Rowntree Foundation (JRF) report recommends co-payment funding model in which care costs are split 80:20 between state and individuals, and removal of means testing. White Paper <i>Our Health, Our Care, Our Say</i> builds on 2005 Green Paper; no specific funding proposals.
2007	2007 Spending Review 'welcomes' assessments of The King's Fund and JRF reports and commits to 'undertake work to look at reform options and consult on a way forward'.
2008	Government runs six-month public engagement exercise about how social care should be funded.
2009 (July)	Green Paper <i>Shaping the Future of Care Together</i> marks launch of 'Big Care Debate'.
2009 (October)	Conservative Party pledges to introduce 'home protection scheme' involving voluntary insurance.
2009 (November)	Government introduces bill that would offer free personal care at home for those with highest needs.
2010 (February)	Informal cross-party talks break down following dispute about compulsory and voluntary approaches - the 'death tax' row.
2010 (March)	Government publishes White Paper <i>Building the National Care Service</i> . The King's Fund publishes review and update of Wanless Report: <i>Securing Good Care for More People</i> . It reiterates case for partnership funding model and proposes a staged, long-term approach to reform.
2010 (May)	New coalition government says it 'understands the urgency of reform' and commits to establishing an independent commission to review options, including voluntary insurance and partnership model.
2010 (June)	Dilnot Commission appointed 'to make recommendations on how to achieve an affordable and sustainable funding system for care and support'.
2011 (July)	Report of Dilnot Commission, <i>Fairer Care Funding</i> , published.
2011 (September-December)	Government engages with care and support stakeholders about priorities for reform; commits to White Paper and progress report on funding in the 'spring'.
2012 (January)	Cross-party talks begin.
2012 (July)	Cross-party talks discontinued. Publication of White Paper <i>Caring for our Future</i> , Progress Report on Funding Reform, and draft Care and Support Bill. Government says it is committed to principles of Dilnot proposals if way can be found of funding them.
2013 (February)	Government announces introduction of social care funding reforms, including capped cost model from April 2017.
2013 (March)	Budget brings forward implementation of capped cost model to 2016, with cap to be set at £72,000.
2013 (May)	Care Bill incorporating clauses to implement the Dilnot proposals placed before parliament

is funded and to finding a more effective and affordable way of sharing the costs and identifying how the increased quantity of resources can be found. The issue has acquired political traction as rising property wealth has taken more people above the capital threshold and required more and more people to fund their care through the value of their assets.

The question of how to pay for care has occupied substantial political, policy, media and campaigning activity in the past 15 years. There have been two independent commissions, three consultations, five White and Green Papers and innumerable reports from think tanks, charities and other organisations.

This paper does not intend to describe or rehearse in detail the meandering course of different reform initiatives since 1999 that are set out in Table 1. It is significant that although social care policy has generally enjoyed broad political consensus since the end of the second world war, recent efforts to achieve cross-party agreement have been acrimonious, igniting serious political conflict in the run-up to the 2010 general election. Agreement has eluded both sets of cross-party talks in the past three years. That so much effort has produced thus far so little in terms of major reform reflects the intractability of the issues involved and the deepening challenges as a consequence of the deteriorating economic and fiscal climate since 2008.

It remains the case that transforming the way social care is funded and delivered will take years to achieve. Sustainable reform, especially in relation to how care is funded, will demand a cross-party consensus and an all-party approach that will endure beyond a single term.

Adult social care in transition

The landscape of adult social care services has changed substantially in the past 25 years, in part due to the unplanned and unintended consequence of decisions made in other policy areas such as social security and the NHS. Four major transformations have called into question the adequacy of current policies and created opportunities and challenges for the kind of system we need for the 21st century. These changes need to be understood to help define the problems that the reform of social care is trying to address.

The most obvious shift has been the rapid expansion of independent residential and nursing care homes and a long-term decline in public sector provision, both local authority and NHS (*see* Figure 1). A total of 92 per cent of residential care and nursing home places for all ages are now provided through private and voluntary providers (*see* Figure 2). Throughout the 1980s the availability of social security funding for care home placements without any kind of needs assessment stimulated massive growth in independent provision, and prompted many local authorities to transfer in-house provision to independent management in order to take advantage of favourable funding arrangements. This rapid and large-scale expansion of private provision was largely unplanned and unaccompanied by any significant debate about the role of private providers in public services. The introduction of needs assessments and changes in funding by community care reforms in the early 1990s saw places contract (although nursing home places have grown for the past three years) but nevertheless cemented the role of the independent providers as the biggest providers of care.

There has been a similar trend in home care (*see* Figure 3), where 89 per cent of hours are outsourced by local authorities to private and voluntary providers.

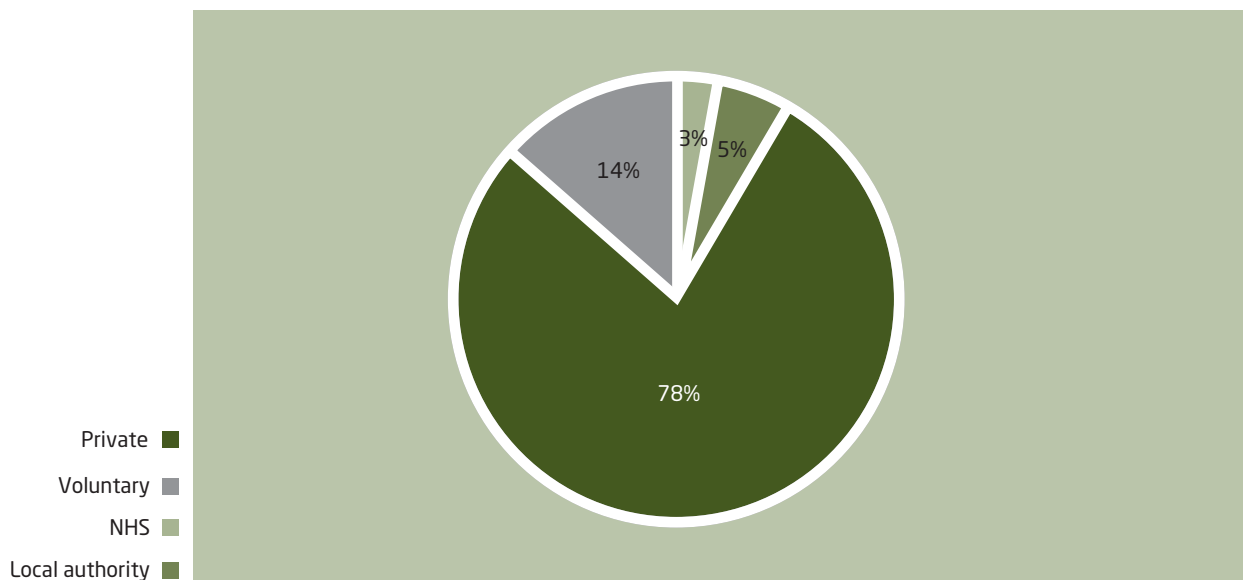
Figure 1 Trends in local authority, independent and NHS care provision: number of places 1980-2012



Note: Surge in NHS places in 1988 is due to Korner classification changes

Source: Laing & Buisson (2013)

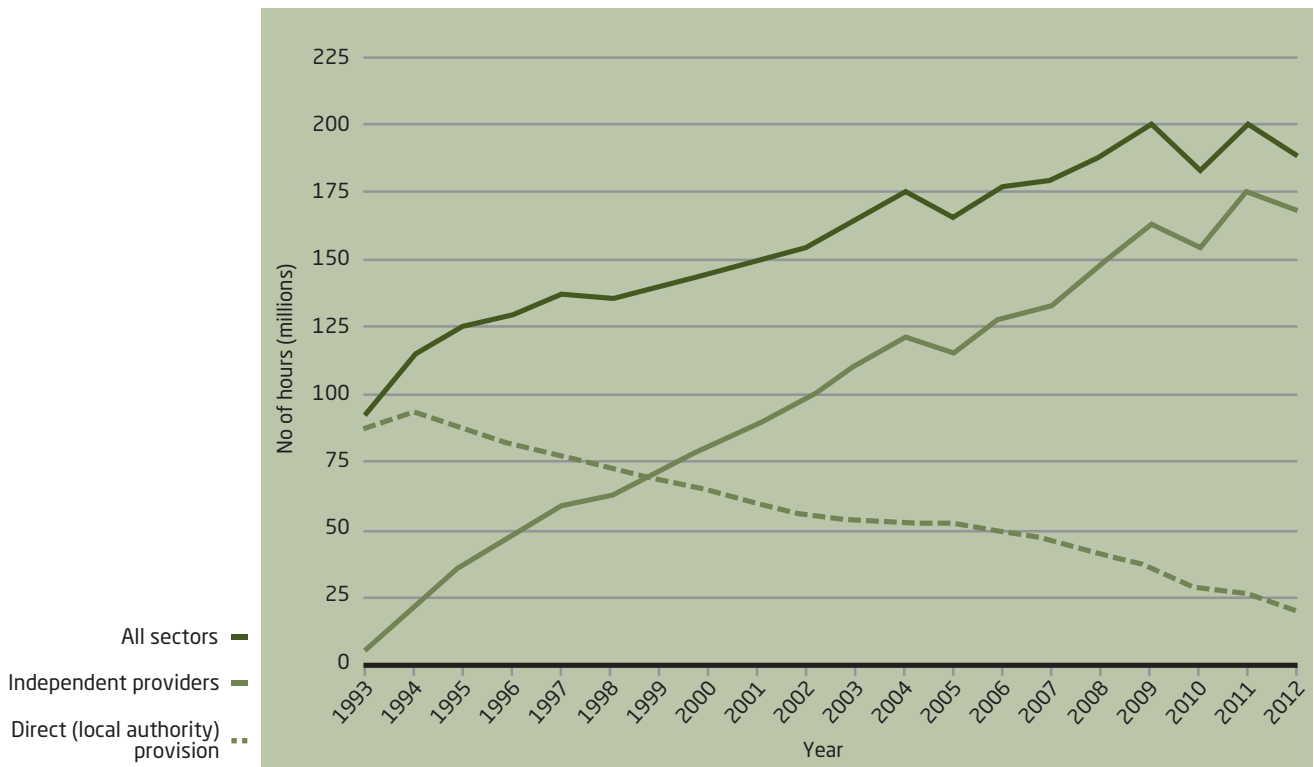
Figure 2 Number of residential care and nursing home places by sector: all ages



Source: Laing & Buisson (2013)

A second major, and ongoing, change is the burgeoning number of people who are funding their own care either because their needs are not high enough to meet local authority eligibility criteria or because their assets do not entitle them to public funding, due to post-war prosperity, good occupational pensions and rising property values. There is a dearth of accurate data about how many private individuals and families fund their own care, what services they use and how much they pay. The Health Survey 2011 suggests that a substantial proportion of older people receiving formal care are funding

Figure 3 Home care - publicly funded, privately delivered: number of hours 1993-2012



Source: Department of Health and NHS Information Centre (2012)

this themselves without recourse to a local authority (NHS Information Centre 2012), and there is good evidence to suggest that in many parts of the country this private economy of care is outstripping the publicly funded system (Institute of Public Care 2012). Laing & Buisson (2013) estimates that 43 per cent of older and physically disabled residents of independent care homes fund the entire cost of their care. It is significantly higher for nursing home residents (49 per cent) than residential care home residents (39 per cent). These figures are broadly consistent with other estimates. If top-up payments to plug the gap between local authority rates and the actual care home fees ('third-party payments') are included, then the total number who contribute to their own care reaches 57 per cent (Laing & Buisson 2013).

There is even less reliable data about people who fund their own care at home. Estimates suggest around 70,000 older people pay for care in their own home. This increases to 270,000 if it is widened to include help with activities such as housework and shopping (Institute of Public Care 2012). Laing & Buisson (2013) calculates that £1.1 billion is spent privately on non-residential services. The extent of the private market varies widely across the country. The highest proportion of self-funding care home residents is in the South East (55 per cent) and the lowest in the North East (22 per cent). Overall it is reasonable to assume that there are at least 400,000 people who are making their own care arrangements in a parallel private economy of care.

However, the infrastructure of information and advice and the kinds of tools available to consumers of other goods and services have not kept pace. There is little signposting of self-funders towards information and advice, especially independent financial advice, and most local authorities' awareness of the circumstances of self-funders in their local population is poor (Carr-West and Thraves 2011). It remains difficult for those with their own resources to make informed choices and to secure good care at a time when the public system is under pressure (National Audit Office 2011; Boyle 2013).

These two shifts – towards private provision and greater private funding – have combined to produce a third trend, which is the emergence of successive cohorts of people since the

1980s who previously would have been entitled to free care via the NHS but are now paying for it from their own resources. A positive benefit is that modern nursing homes can offer a better environment and quality of care than the long-stay wards that preceded them. This is a trade-off that has been arrived at almost entirely by stealth in an unplanned way without explicit debate, decision or scrutiny. It has led to changes in the boundary between health and social care and in the responsibilities for paying for it, and this affects more and more people.

As the population ages, and with the growth in long-term conditions, co-morbidity and dementia, the current distinctions between health and social care needs will become increasingly unsustainable and hard to defend. Following the introduction of a new national framework from 2007, those entitled to continuing NHS health care has grown by 28 per cent since 2009 – ranging from an increase of more than 100 per cent in the East of England to an actual reduction of a third in the area then covered by the South Central Strategic Health Authority (Hansard 2009–10).

A final transformation that is more recent and still under way is a shift towards approaches based on personalisation, choice and control. In recent years there has been a rapid growth in personal budgets and a shift towards self-directed support as the default model of delivery for the majority of people with care and support needs (LGA 2012). There is a wider appreciation of the value of asset-based approaches that emphasise the potential for communities and individuals to generate their own support. These changes are beyond the scope of this paper but it is important to recognise their centrality to the reform of how social care is *delivered*.

The cumulative bequest of these four trends is a system that is criss-crossed with fault lines in how services are funded, commissioned, provided and regulated – between NHS and local authority social care, private and public funding, and private and public delivery.

The growth of private finance in social care provision has left people's care arrangements vulnerable to business failure, and policies for economic regulation and market oversight have not kept pace.

Public funding, as we shall see, has been gradually skewed towards a tightly rationed system focusing on fewer people – those with highest needs and lowest means. More and more people are becoming disengaged from a care system that is increasingly dysfunctional, driven by crisis rather than the promotion of wellbeing and prevention.

Although policy responses to address a fragmented and confusing set of arrangements have produced some benefits, they have often added more complexity and reinforced service and funding silos, for example, continuing health care and free nursing care.

Whereas technology has been a major driver of service delivery – and costs – in health care, it has played little part in spurring innovation in the delivery of social care, where some excellent examples have struggled to be adopted at scale and pace (Ayres 2013).

The cumulative effect of these issues is to deepen confusion and uncertainty about how care is funded, for the individual, local authorities and the state. These accretions of history are no substitute for a clear or coherent policy framework through which we can address the challenges of care.

Present and future pressures

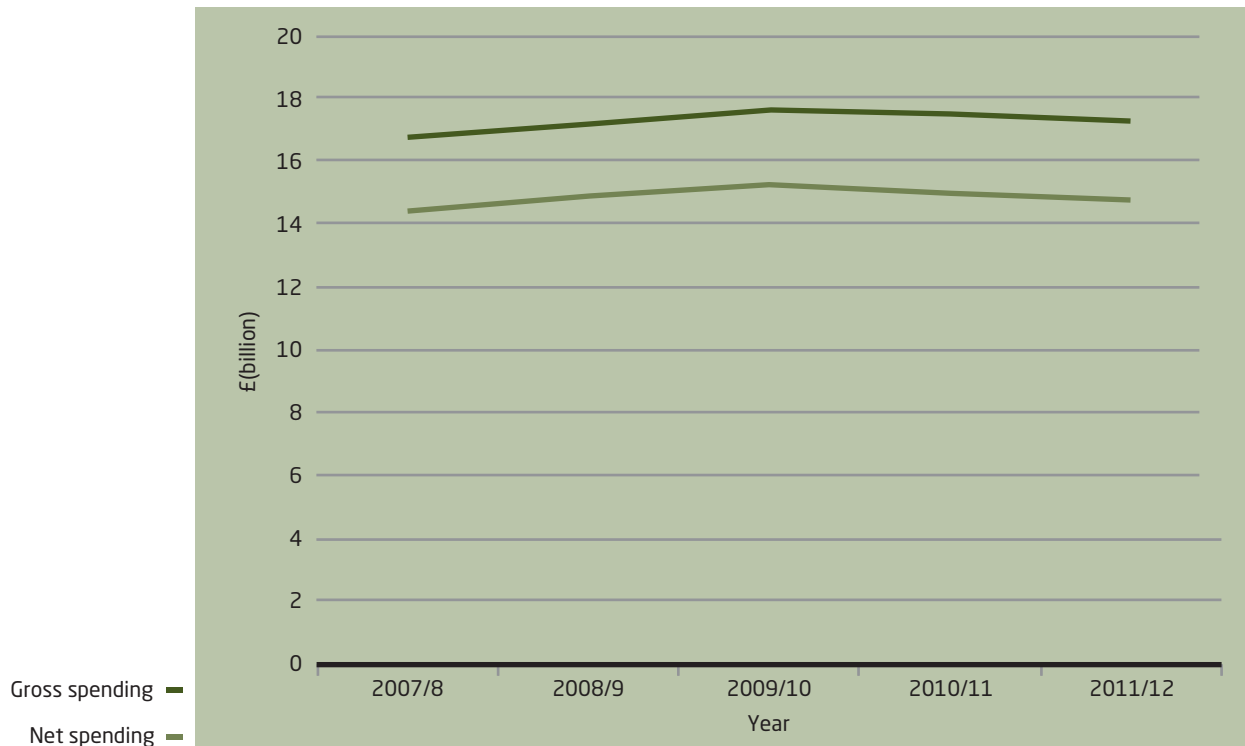
There has been mounting concern about the adequacy of funding for the existing social care system. Previous analysis (Humphries 2011) recognised that the government had acknowledged pressures on the system by allocating additional resources through the 2010 Spending Review. But following the Chancellor's 2012 Autumn Statement, local

government has experienced one of the toughest settlements of all spending departments and now faces further cuts in 2015.

Although the number of people needing social care is growing, actual spend is falling, fewer people are receiving help and, as we have seen, more people continue to fall outside of the system.

For most of the past decade, spending on adult social care rose in real terms, but it began to plateau and then fall towards the end of the decade (*see* Figure 4). Local authorities have reduced their adult social care budgets for the past four years, with a planned reduction of £800 million in 2013/14. By March 2014 spending will have fallen by £2.68 billion – a cut of 20 per cent over the current Spending Review period (Association of Directors of Adult Social Services 2013). Councils have sought to prioritise spending adult social care as far as possible – and they have a strong track record of delivering efficiency savings in this area (Think Local Act Personal (TLAP) 2013b). Of the planned reductions this year, 82 per cent (£651 million) will be met through efficiency savings and redesigning services, 5 per cent through higher charges and 13 per cent through reduced services.

Figure 4 Spending on local authority social care, 2007-12



Source: NHS Information Centre (2012)

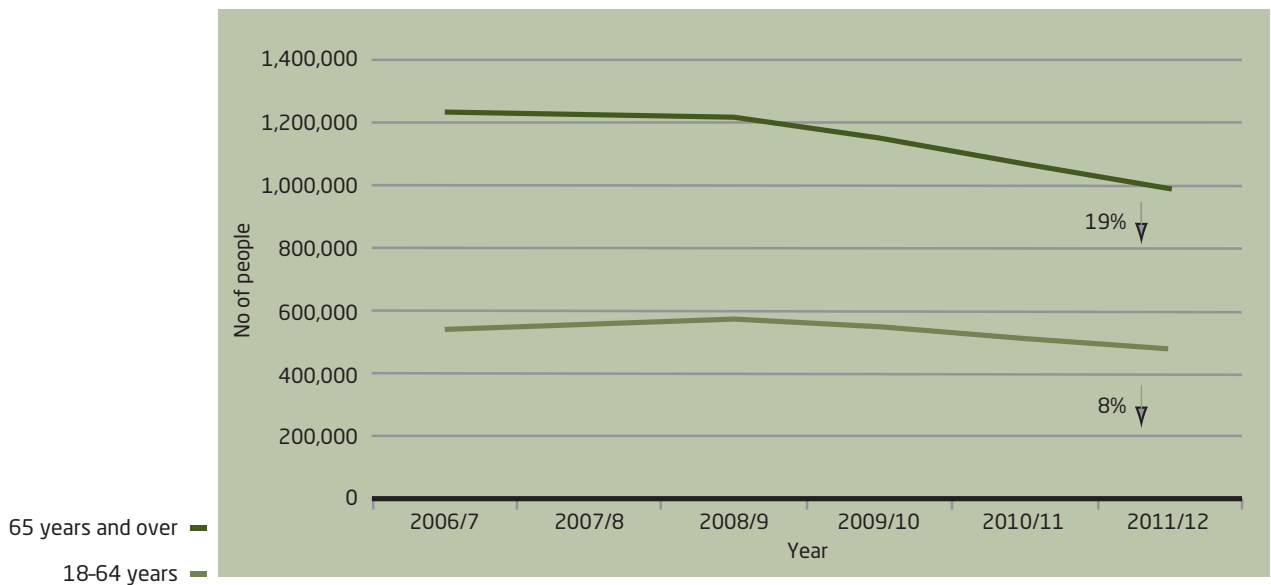
The transfer of NHS resources announced in the Spending Review is helping, but not always in the way intended. Of the money allocated from the NHS to promote joint working this year, 32 per cent (£253 million) is being used to offset cuts to services and to help meet demographic pressures (*see* below). Without this funding, local authorities would have to make further reductions in spending of almost 7.5 per cent in 2012/13.

It continues to become more difficult for people to access care, with 87 per cent of councils now responding only to needs that are classified as substantial or critical under the Fair Access to Care eligibility criteria, compared with 47 per cent in 2005/6 (Association of Directors of Adult Social Services 2012). Fewer people – both older people and those of working age – are receiving publicly funded care, a trend that began in 2008 (*see* Figure 5). The fall has become steeper since 2010, with an overall drop of

nearly 14 per cent. The reduction is even greater among older people, especially in the use of community-based services (see Figure 6). This is worrying given the emphasis on promoting independence and care at, or closer to, home. Over the same period, the population aged 85 years and over has soared by more than 20 per cent. There is evidence that the number of people providing informal care has increased substantially – those providing unpaid care of 50 or more hours per week has increased by 26 per cent over the past decade (Carers UK 2012). Inadequate support that causes carers to leave paid employment has wider economic effects, with a public expenditure cost of £1.3 billion a year (based on the costs of the carer’s allowance and lost tax revenues) according to one estimate (Pickard 2012).

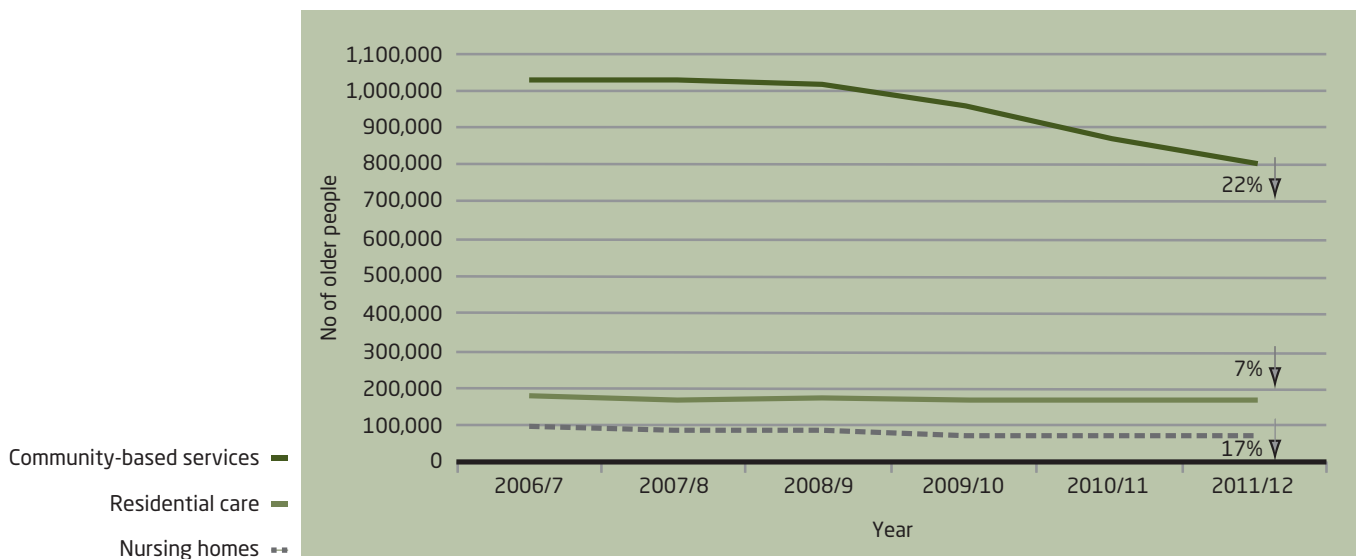
While local authorities have been placing fewer people in residential and nursing homes, overall capacity in this sector has been rising steadily since 2007, reflecting the increasing numbers of people funding their own care.

Figure 5 Number of people receiving publicly funded care 2006-12



Source: Health and Social Care Information Centre (2013)

Figure 6 Number of older people receiving different types of care 2006-12



The national trends described here conceal wide differences in spending and services from one local authority to another. For example, there is a seven-fold variation between local authorities in the number of people receiving intensive home care, and a ten-fold variation in the numbers receiving direct payments; similar differences can be seen in the use of residential and nursing homes. There are many reasons for these variations, which are likely to be accentuated by the different impact of budget reductions from one place to the next (TLAP 2013a). The implications of these differences are that national trends require careful local interpretation in order to understand what changes are needed and that some local authorities will find it much more difficult to find further efficiency savings than others.

Another issue of concern is evidence of downward pressure on the fees paid to providers when there is significant and growing concern about the quality of care. The fees paid by councils to providers increased by only 0.9 per cent in 2012/13 – well below the rate of inflation. This year 45 per cent of councils are planning no increase in fees to care homes for older people to cover inflation. While the relationship between price, cost and quality is not straightforward – and it is reasonable that providers should contribute to the efficiency challenge – it is difficult to see how they can maintain, let alone improve, the quality of care they provide within these parameters. In a recent survey 46 per cent of directors of adult social services felt that the quality of services they had commissioned had declined in the past 12 months (Appleby *et al* 2013). It is even more ominous that 48 per cent of directors of adult social services report that providers are facing financial difficulty now as a consequence of reductions in their budgets and 57 per cent think this also will be the case over the next two years (Association of Directors of Adult Social Services 2013).

A particular dilemma for local authorities is how to balance the imperative of responding to the growing demand for intensive support for relatively few people who have multiple and complex needs with investment in prevention and lower levels of service that promote independence and enable people to stay well. Prevention and early intervention are important objectives of the government's reforms, recognising the significant role played by social care in helping older people to remain independent. With an ageing population and changing patterns of disease, the need for preventive services has never been greater. Yet cuts in local government budgets have resulted in resources being increasingly focused on people whose needs are substantial or critical. They are making it harder for local authorities to invest in relatively simple and inexpensive interventions that help people in their own homes. A recent study commissioned by the British Red Cross illustrates the risks of avoidable admissions to hospitals and care homes as a result of the neglect of prevention in social care (Deloitte 2012). There is a real risk that insufficient investment in prevention will increase future demand for health and care services when the overriding challenge is to reduce it.

It is important to note that the overall trend of falling spending and fewer people receiving services had begun before the cuts in local government spending as a result of the 2010 Spending Review and the further cuts announced in the Chancellor's Autumn Statement. This indicates that there is a deeper structural imbalance between the volume of care needs, how the current system responds, and the resources available. Models of projected spending by the Personal Social Services Research Unit (PSSRU), LGA and Institute for Fiscal Studies all show that the gap between needs and resources will continue to widen.

Estimating the current and projected shortfall in funding is difficult for a variety of reasons. Quantifying the extent of unmet need is not straightforward, and estimates based on the future costs of the current system overlook the benefits that could be achieved through a reformed system that produces better outcomes.

Table 2 Additional net cost of setting national minimum eligibility criteria at moderate needs (£m)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Older people	1,209	1,272	1,321	1,348	1,430	1,491	1,529	1,576	1,641	1,714	1,774
Adults with physical disabilities	298	299	300	301	301	302	312	321	330	340	349
Adults with learning disabilities	340	347	353	360	366	373	387	402	416	430	445
Adults with mental health and other needs	178	178	179	179	180	180	185	191	196	201	206
Total – all groups	2,025	2,096	2,153	2,188	2,277	2,346	2,413	2,490	2,583	2,685	2,774

Source: Fernandez *et al* (2013)

Bearing in mind that caveat, the potential scale of the existing shortfall can be illustrated by estimating the costs of adopting a more generous approach to eligibility in which all local authorities offer help to everyone with moderate needs. This would see 23 per cent more people receiving services. For older people, this would involve additional net public expenditure of £1.2 billion, rising to £2.2 billion by 2020 (in 2010 prices). For working-age people with social care needs, the additional net spending would be £820 million, rising to £1 billion by 2020 (Fernandez *et al* 2013). This suggests that the total extra cost of meeting moderate, as well as substantial and critical, needs could be in the region of £2 billion (*see* Table 2). These sums would be on top of the costs of implementing a cap on costs and an extended means test.

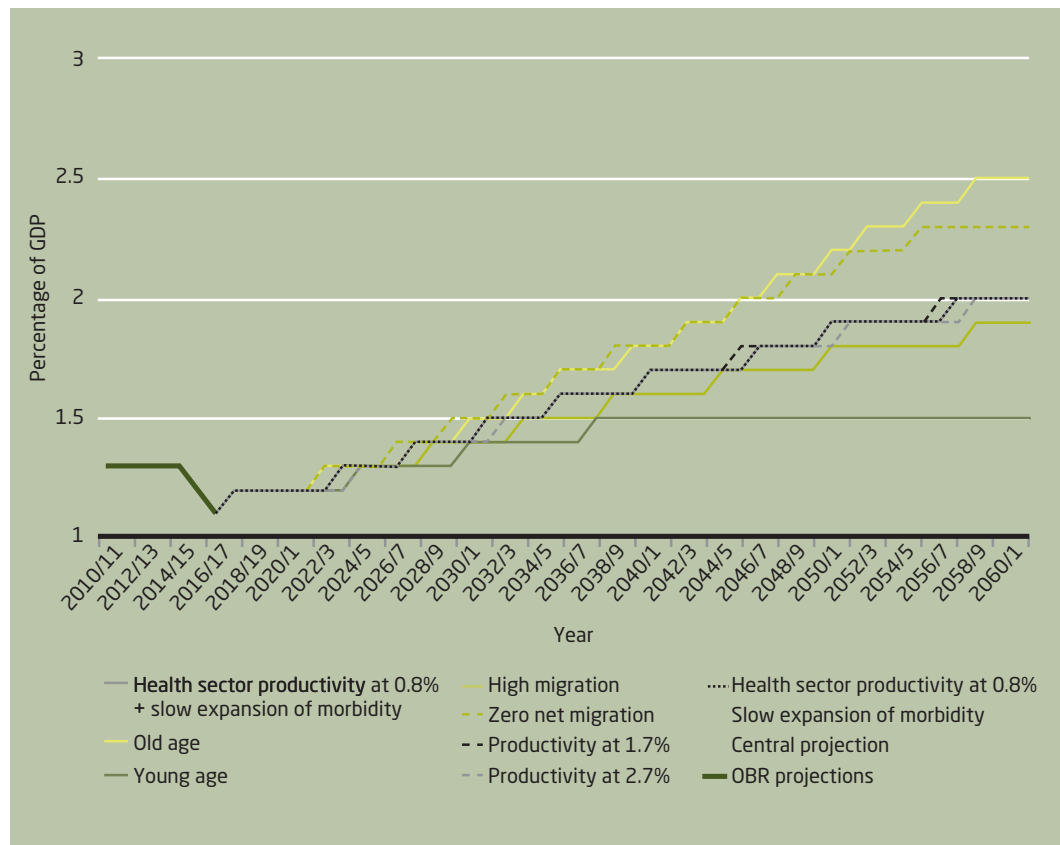
Demographic pressures are unremitting. Projections suggest that by 2030 there will be almost twice the number of people aged over 85 that there is now (Office for National Statistics 2011); 600,000 more older people will have significant care needs by 2030 (Wittenberg *et al* 2011). More working-age adults will need care and support, as life expectancy for this group is rising. It is estimated that by 2030 the number of younger adults (aged 18–64) with learning disabilities will have risen by 32.2 per cent to around 290,000, and the number of younger adults with physical or sensory impairment by 7.5 per cent from almost 2,900,000 to 3,100,000 (Snell *et al* 2011).

The most recent projections of the Office for Budget Responsibility (OBR) suggest that long-term care spending will rise from 1.1 per cent of GDP in 2016/17 to 2 per cent by 2061/2 (OBR 2012). It should be noted that these are projections based on demography alone and will be influenced by a range of factors including changes in productivity, population health and migration (*see* Figure 7).

These projections indicate that by 2062 combined health and social care spending will have increased as a proportion of public spending by more than any other area of government spending – up by 3.2 percentage points of GDP. As Appleby (2013) has noted, most European countries face upward pressure on health and care costs. But it is significant that the ageing of the population is not the most significant factor that will drive higher spending – changes in technology, the size of national income and the costs of providing care will be bigger factors. Higher spending is a ‘credit’ as well as a ‘debit’ in that it boosts health, wellbeing and quality of life and brings wider economic benefits. The issue is not about the affordability – in absolute terms – of spending more on care but about the political and social choices concerning how much should be spent, what it should be spent on and how the funding should be raised.

In summary, there are immediate pressures on social care budgets arising from local government budget cuts and a longer-term need to devote more of our GDP to the costs of long-term care. To what extent will the government’s recent announcements to reform social care funding in line with the recommendations of the Dilnot Commission help meet these challenges?

Figure 7 Projected spending on long-term care 2016/17-2061/2



Source: OBR (2012)

Note: Figures for 2011/12 to 2015/16 are estimates; future projections start from 2016/17

The Dilnot Commission and the government's response

The proposals summarised

In line with the commitment of the coalition's programme for government in May 2010, the Dilnot Commission was established to consider how best to achieve an affordable and sustainable funding system for care and support for all adults in England. Its terms of reference had a particular focus on:

- how best to meet the costs of care and support as a partnership between individuals and the state
- how people could choose to protect their assets, especially their homes, against the cost of care
- how, both now and in the future, public funding for the care and support system can be best used to meet care and support needs
- how its preferred option can be delivered.

It is important to note that the Commission's terms of reference excluded consideration about the total quantity of resources needed for the social care system and where this should come from – in terms of previously canvassed options such as comprehensive or voluntary insurance, or new or additional taxation.

So from the outset the Dilnot Commission's task was limited to one particular, though clearly important, aspect of social care funding reform. The Commission reported in July 2011; its main recommendations are summarised in Table 3 (Commission on Funding of Care and Support 2011).

Table 3 Main recommendations of the Dilnot Commission and the government's response

Recommendation	Government response
1. To protect people from extreme care costs, there should be a cap on the lifetime contribution to adult social care costs that any individual needs to make at between £25,000 and £50,000. Where an individual's care costs exceed the cap, they would be eligible for full support from the state.	Accepted - cap to be set at £72,000 from 2016, with a lower cap (to be decided) for working-age people.
2. To extend protection to people falling just outside of the means test, the asset threshold for those in residential care beyond which no means-tested help is given should increase from £23,250 to £100,000.	Accepted - the upper capital threshold for means-tested support will rise to £118,000 from 2016/17 (equivalent to £100,000 in 2010/11 prices) and the lower threshold to £17,000 (equivalent to £14,250 in 2010/11 prices).
3. Those who enter adulthood already having a care and support need should immediately be eligible for free state support to meet their care needs, rather than being subjected to a means test.	Accepted - there will be a zero cap for people who turn 18 with eligible care and support needs.
4. Universal disability benefits for people of all ages should continue as now. The government should consider how better to align benefits with the reformed social care funding system, and attendance allowance should be re-branded to clarify its purpose.	The government has not commented on this recommendation.
5. People should contribute a standard amount - £7,000 to £10,000 yearly to cover their general living costs, such as food and accommodation, in residential care.	Accepted - from 2016 people in residential care should pay a contribution of around £12,000 yearly towards general living expenses (£10,000 in 2010/11 prices).
6. Eligibility criteria for service entitlement should be set on a standardised national basis - in the short term at substantial - to improve consistency and fairness across England, and there should be portability of assessment.	Accepted - the Care Bill makes provision for a national minimum eligibility threshold, to be in place from 2015 and the level to be determined through regulations.
7. The government should also urgently develop a more objective eligibility and assessment framework.	The government has said it will 'develop and test options for a potential new eligibility and assessment framework'.
8. To encourage people to plan ahead for their later life, the government should invest in an awareness campaign to inform people of the new system and the importance of planning ahead.	See below.
9. The government should develop a major new information and advice strategy to help when care needs arise, in partnership with charities, local government and the financial services sector. As proposed by the Law Commission, a statutory duty should be placed on local authorities to provide information, advice and assistance services in their areas, irrespective of how people's care is funded or provided.	Accepted - the government has committed to providing a 'clear, universal and authoritative source of national information about the health, care and support system'. The Care Bill places a new duty on local authorities to ensure that information and advice is provided locally, and the government is setting up an expert working group with financial services, local authorities and the care sector to support the development of an information offer.
10. Carers should be supported by improved assessments and have new legal rights as recommended by the Law Commission.	Accepted - the Care Bill contains new provision to strengthen the rights of carers.
11. The government should make a clear statement that disability-linked annuities are permissible under current pension taxation rules.	The government has said it will clarify the tax treatment of disability-linked annuities.
12. The current deferred payment scheme should be extended so that it is a full universal offer across the country.	Accepted - deferred payments will be available in all local authorities from April 2015, as reflected in the Care Bill.
13. In reforming the funding of social care, the government should review the scope for improving the integration of adult social care with other services in the wider care and support system - in order to deliver better outcomes for individuals and value for money from the state.	Accepted - taken forward through new powers and duties in the Health and Social Care Act 2012, through the Care Bill and through the forthcoming Common Purpose Framework.

Source: Commission on Funding of Care and Support (2011)

The government responded to the Commission's proposals by recognising that they would have significant costs and would need to be considered as part of the wider reform of social care delivery in the context of the Law Commission's proposals for fundamental reform of adult social care law (Law Commission 2011).

Following a period of engagement with the care sector, the government set out its overall proposals for reform in the White Paper *Caring for our Future* (HM Government 2012b), accompanied by a separate progress report on funding reform (HM Government 2012a) and a draft Care and Support Bill (HM Government 2012c) in response to the recommendations of the Law Commission. The government stated its support for the central proposals of the Dilnot Commission – a capped cost model and extended means test – as the right basis for reform but because of the fiscal climate was 'unable to commit to introducing a new system at this stage'. The government also signalled that there were unresolved questions about how the principles of a capped cost model would work in practice, and highlighted in particular:

- the level at which the cap should be set, how the cap should rise over time, what should and should not be counted in the cap, and the contribution to general living costs that people should be expected to make
- whether there should be a voluntary or opt-in arrangement, where people have a choice to pay a specified amount to receive financial protection from the state, so as to ensure that those who benefit most from reform should be asked to meet its cost.

However, in February 2013 the government announced that it would introduce a full version of the Dilnot capped cost model from 2017 but at a higher level of £75,000 (£61,000 in 2010 prices) and an extended means test (Department of Health 2013a). Subsequently the 2013 Budget has brought forward implementation to April 2016 with a cap on care costs of £72,000 (HM Treasury 2013). Following the publication of a draft Care and Support Bill and a pre-legislative scrutiny process, a Care Bill incorporating these proposals has been placed before parliament (HM Government 2013).

The proposals assessed

How far will these proposals address the challenges facing the care and support system that have been highlighted earlier? They should bring four positive benefits.

The introduction of the capped cost model is the first time in the history of the welfare state that the government will place a limit on how much people have to pay for their social care. It extends the same protection from catastrophic bills to social care that – thanks to the NHS – we have always enjoyed in relation to health care costs. It will see everyone as potentially entitled to public funding and thus will begin to dissolve demarcations between public and private funding that have become such a strong feature of the system in recent years. It extends to the whole population access to information, advice and assessment and marks a shift towards a new and much more universal settlement for care and support, a distinctive break from the residual means-tested model that has been predominant since 1948. This is an important development; its symbolic policy significance should not be underestimated at a time when public finances are under unprecedented strain and when the state is, if anything, retreating from further public expenditure commitments rather than expanding them.

A second benefit is that the combination of a cap on care costs (around £60,000 in Dilnot's 2010 prices) and the extended means test will see as many as 100,000 more older people receiving public funding towards their care costs. Those benefiting from financial help under the extended means test will see this count as part of their spend towards the cap – so the cap for them will be less than £72,000. It is significant that the government has abandoned its interest in pursuing a 'voluntary' version of Dilnot in which people

could individually opt in or out of the protection offered by the cap. This means that the reforms will offer comprehensive protection against care costs with what is, in effect, an 'excess' payment of £72,000.

The main beneficiaries of these changes are likely to be people with relatively high needs and with modest assets (that is, between £23,250 and £150,000). The proposed cap of £72,000 is higher than the £35,000–£50,000 proposed by Dilnot in 2010 – though when adjusted from 2016 prices the comparable amount is around £60,000. In the current fiscal climate it is unsurprising that the government has set the cap at a higher level in order to reduce the costs of the reforms to the public purse. But once the cap is in place, there will be nothing to stop future governments from lowering it, thus extending the coverage, as perceptions of affordability and fiscal circumstances change.

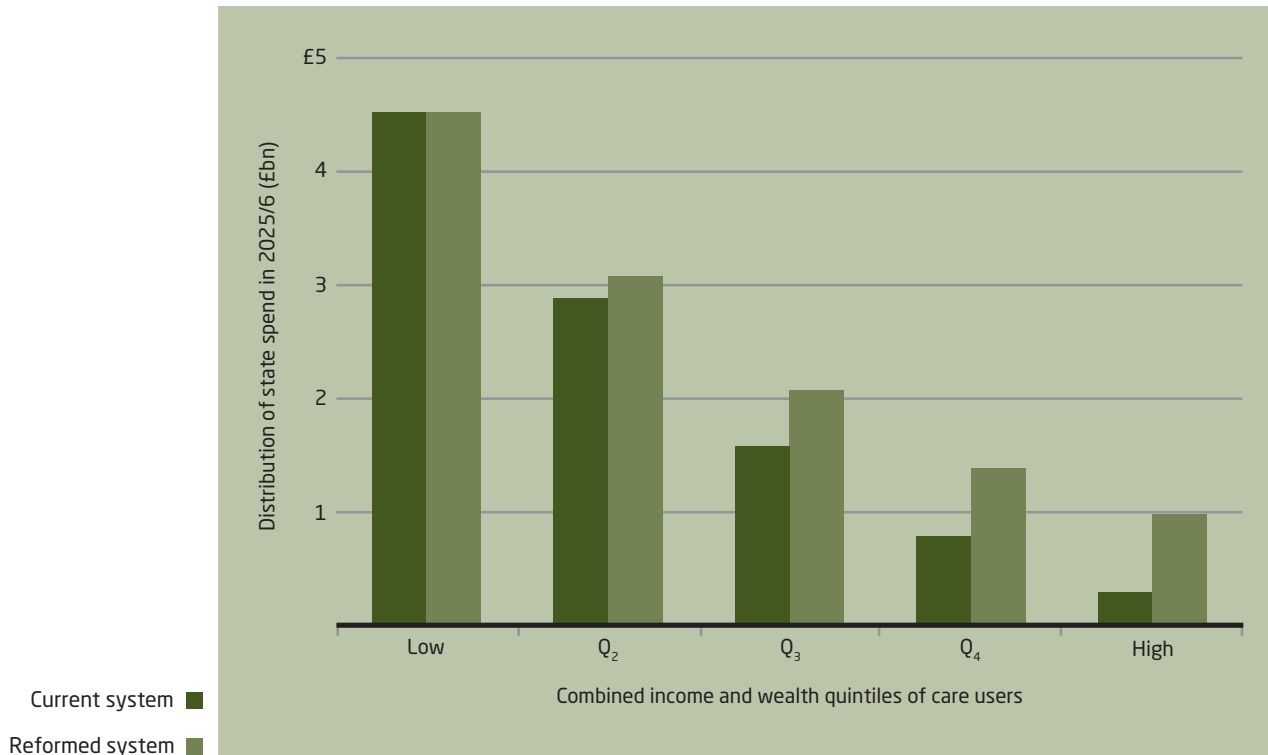
A third benefit is that it brings social care out of the shadows and sets a clear framework of expectations about how care costs are shared between the individual and state, a partnership approach we have consistently advocated since the late Derek Wanless's seminal report *Securing Good Care for Older People* (Wanless 2006). The unpredictability of care needs and the absence of any effective way for people to protect themselves from catastrophic costs have been well documented as a major failing of the current system. Taking away the uncertainty about where responsibility for the unpredictable costs of care might fall makes it much easier for individuals to plan ahead. It might also stimulate the development and promotion of new or existing financial products to offer people more choices in planning for care costs, though evidence for this is mixed (Lloyd 2011; Forder and Fernandez 2011).

An important aspect of the reforms is their impact on working-age people with care and support needs, who represent around one-third of people using adult social care. Their circumstances have often been overshadowed in the debate by those of older people. A welcome improvement will be that people who reach the age of 18 with eligible needs will be entitled to free care – that is, their cap will be zero. Although it is often assumed that most working-age people with care and support needs are entitled to free care anyway (because they have not acquired sufficient income or wealth to contribute under the means test), that may well change as increasing numbers of children with disabilities live into adulthood and inherit from their parents. However, the proposals in their current form will offer limited benefit to those who develop care and support needs during adulthood. There will be a lower cap on care costs, yet to be decided, and it is likely that most will continue to be dependent on means-tested support. The primary question for this group is not how they can be protected from catastrophic care costs but what level of funding is required to ensure that they have access to an adequate level of support (Brawn *et al* 2013).

A final advantage of the government's proposals, which has attracted less attention, concerns the way in which the reforms will be funded. In the 2013 Budget the government stated that the cost of these changes will be met through higher employer national insurance contributions arising from the end of contracting-out for members of defined benefit occupational pensions and by freezing the inheritance tax threshold, so 'providing a simple and fair way of ensuring that those with the largest estates, who are more likely to benefit from social care reform, help to fund it' (HM Treasury 2013). This is the first time the government has sought to establish a relationship between those who will benefit from the reforms and those who will pay. This helps to open up the debate about how the overall costs of care could be met in the future and – as part of this debate – the various options for where to find the necessary money.

Although the original proposals of the Dilnot Commission were welcomed by the care sector, some have argued that this would amount to using public money to protect the inheritances of relatively wealthy families who can afford to pay for care (Redwood 2012)

Figure 8 Public spending on care and support for older people by wealth quintile (2012/13 prices)



Source: Department of Health (2013)

and the proposals will disproportionately benefit the better-off. It has been suggested that instead the first priority for any additional funding should be to improve the care of the poorest people (Centre for Social Justice 2012). These arguments overlook the evidence of increasing numbers of people with relatively high needs and modest means (that is, more than £23,250 under the current means test) who are faced with unpredictable and, for some, very high levels of care costs. Because they fall outside the publicly funded system, they face a further disadvantage in that they may not receive the benefits of information, advice or professional assessment.

As the poorest people already receive free care, it will be impossible for any reforms to demonstrate that their position has improved, and in terms of the distribution of benefits across the whole population anyone who is better off than the poorest will appear to gain. It remains the case that care and support spending is highly progressive – nearly two-thirds would be spent on the lowest two income and asset quintiles and only 8 per cent on the highest quintile (see Figure 8). The overall distributional impact will depend also on how, and from whom, the additional funding is raised – that is, who pays. The government’s intention to pay for the reforms through changes to national insurance contributions and the freezing of inheritance tax thresholds will, if anything, increase their progressive effect.

Reactions to Dilnot and the government’s proposals have exposed a view about who should pay for social care that is very different from orthodox thinking about who pays for the NHS. Few question that the NHS should provide free care for the relatively wealthy – need is the principle that overrides personal income or wealth. In relation to social care, however, some argue that those who can afford to pay for their care should be expected to do so. As greater priority is being given to the integration of health and social care, the dissonance between how the two services are funded will become a bigger issue.

But as well as the positive benefits of the government’s proposals, there are some major challenges and difficulties.

Overall it is evident that implementing the proposals will involve an immense amount of detailed planning for a potentially complex new set of arrangements. This will fall primarily on local authorities at a time when they are experiencing the toughest financial challenges in their history. The biggest areas of additional work are summarised in Table 4.

Table 4 Implementation activity

Activity	By
Identifying numbers of local population who are already self-funding, understanding their circumstances and modelling potential resource requirements	Immediate
Establishing a deferred payment scheme, or modifying existing scheme	April 2015
Assessing implications of introducing a national minimum eligibility threshold set at substantial	April 2015
Making arrangements for additional assessments that will be required	April 2016
Ensuring access to information and advice services	April 2016
Local public relations and communications plan	April 2016
Putting in place arrangements for 'care accounts', including metering of spend up to the cap; this will include separation of care costs from general living expenses	April 2016
Implementing extended means test	April 2016
Assessing overall implementation costs in context of additional responsibilities and volume of work arising from the Care Bill	Ongoing

Some extra administrative costs and processes are inevitable. The simplest system of care funding is through general taxation or leaving people to fend for themselves with the barest means-tested safety net. In either case the transactional costs are minimal. Moving towards any kind of partnership funding model – capped cost or otherwise – will involve new systems of individual care accounts to monitor private contributions and spending on care alongside public funding.

A further issue is that the government, in addition to introducing a capped cost model, has agreed to implement a new policy proposition, emanating originally from the 1999 Royal Commission, that general living or 'hotel' costs should be separated from care costs. Most policy options for funding long-term care rest on the premise that accommodation costs should not be a function of the care system. People face accommodation costs wherever they live and there is a long-established principle that people who need help with these should receive it through income maintenance – for example, housing benefit, social security or pension credit. So people in residential care will be expected to make an annual contribution of around £12,000 a year towards their living costs as well as contributing up to £72,000 towards the lifetime costs of their care. This adds a further layer of preparatory work in establishing systems for these costs to be identified, agreed, invoiced and collected.

The challenge is further compounded by the fact that not all spending by individuals on their care will necessarily count towards the cap. Spending that qualifies towards the cap will be based on 'eligible' care and support needs – based on a national minimum threshold to be set later through regulations – and, crucially, on what the local authority would expect to pay for services to meet those needs. This is not an unreasonable principle – few would argue that the state should underwrite whatever level of care, however opulent, individuals might opt to fund themselves. The consequences of such arrangements are already apparent when individuals who have exhausted their own resources in relatively luxurious care homes expect their local authority automatically to pick up the bill. However, the potential for confusion and complaints arising from disparity between actual spending and the notional costs assessed by local authorities is very substantial. It is unclear how local authorities will assess notional costs, but some kind of resource allocation system seems the likeliest approach. The Joint Committee on

the Draft Care and Support Bill has warned of an increase in the number of disputes and legal challenges (House of Lords, House of Commons 2013).

In the short term the introduction of the capped cost model will expose other flaws in the current system. For example, the extent of cross-subsidisation of publicly funded care home residents by self-funders will call into question the level of fees paid by some local authorities to care homes (Laing & Buisson 2013).

Many of these issues arise less from the Dilnot recommendations themselves and more from the intrinsic defects of the current system. The starting point for introducing these reforms is a low level of public understanding of how care is funded under existing arrangements and the extent to which long-term care has drifted from an NHS responsibility to a means-tested system in which the liabilities of individuals for their care costs are potentially limitless.

Without a major and sustained public relations and awareness campaign, there is a real danger that many will see the reforms as a worse alternative rather than an improvement to the actual realities of the current system.

In summary, the proposals do amount to an important milestone in the tortuous journey towards a better way of funding social care. In the context of the most daunting financial circumstances facing any government in peacetime, they are a significant achievement, but implementing the proposals will not be straightforward and attention should now focus on those parts of the reform agenda that the current proposals do not reach.

Beyond Dilnot

Although much of the debate on the Dilnot reforms has been about the level of the cap, of even greater significance is the level at which the proposed national minimum eligibility threshold will be set. With 87 per cent of local authorities responding only to substantial needs or higher, it is difficult to see how this will be set any lower. As one study in relation to working-age people with care needs puts it, 'the critical question is not how high a cap on care costs should be, but whether their needs are even deemed eligible for support' (Brawn *et al* 2013). The cap and extended means test will be irrelevant if people with moderate needs fall outside the public system. As the number of people with care and support needs continues to grow, the level of unmet needs will rise too, and the system will become even more reactive and crisis-driven. This will place further pressures on unpaid carers alongside some of the potential consequences of the Welfare Reform Act.

Further reductions in local government grants from 2015, in addition to the cuts announced in the 2010 Spending Review, will make it extremely difficult for councils to protect, let alone improve, investment in services that promote wellbeing and help to deflect or postpone the need for formal health and care services. The consequences of rising pressures on the social care system for the NHS have been set out elsewhere (Humphries 2011). More than one-third of directors of adult social services anticipate having to reduce services in the next 12 months, one-third predict their budget will be overspent this year, and nearly three-quarters are pessimistic about the financial prospects facing their local health and care system (Appleby *et al* 2013).

As we have noted, the terms of reference for the Dilnot Commission excluded consideration of the total resources needed for the social care system and where this money should come from. Nevertheless, it was clear that '...the government must devote greater resources to the adult social care system. As well as funding for new reforms, additional public funding for the means-tested system is urgently required' (Commission on Funding of Care and Support 2011).

The Health Select Committee in its 2012 inquiry was also unequivocal: 'We consider that the current social care system is inadequately funded. People are not receiving the care

and support that they need and the quality of services is likely to suffer as a result.' It said the government 'must face the issue of the existing "funding gap" in social care services – ie, the gap between the number of people who need care (and the level of their care need) versus the amount of money that is currently in the system to deal with their needs' (House of Commons Health Committee 2012).

Even the government argued that although the Spending Review settlement for social care should mean that eligibility thresholds did not need to rise, '...it was not expected to fund the level of unmet need that the government inherited and in this sense a needs gap remains' (HM Government 2012d).

The Joint Committee on the Draft Care and Support Bill made a fundamental point that 'the overall level of funding available for the care and support system will impact on how far the reforms envisaged in the draft Bill and the government's White Paper can be realised, particularly the stated goal of shifting the emphasis from crisis intervention to prevention and early intervention' (House of Lords, House of Commons 2013).

The House of Lords Select Committee on Public Service and Demographic Change has concluded that the social care system is already 'in crisis' and has recommended an independent commission to analyse how the health and social care system and its funding should be changed to serve the future needs of our ageing population (House of Lords 2013). So it is clear that the government's decisions on funding reform should be a stepping stone on a journey of wider reform of the system for both funding and delivering social care.

Ways forward

There are three major questions that the next stage of social care funding reform should seek to address.

The first concerns the overall resources that will be needed to meet future needs and expectations and where this money should come from. It will become increasingly difficult to address this question without considering the future funding needs of the NHS. In broad terms the potential sources are to:

- raise additional revenue through general taxation
- introduce a new form of taxation, such as a new hypothecated inheritance tax or 'care duty' levied on estates
- redirect existing expenditure such as the present tax, national insurance and universal benefits for older people.

Constraints on public expenditure are likely to continue for the foreseeable future, so it is probable that the search for future funding will focus on the relatively high levels of property wealth in the older population and on the potential to redirect existing expenditure on universal benefits for older people. This is particularly the case as this group in general terms has suffered least as a result of the government's fiscal reduction programme. As we have seen, the government has acknowledged that those who will benefit the most from the reforms should be expected to contribute towards their costs.

It is important to emphasise that there is a major structural imbalance in public spending on older people, with just 9 per cent of the total devoted to essential care needs. This amount has been subject to evermore draconian rationing, compared with the large sums of public money disbursed through universal benefits – such as winter fuel allowances, free TV licences and public transport – to all regardless of their needs, income or wealth. The Institute for Fiscal Studies has demonstrated that very substantial sums could be identified from relatively modest, if controversial, adjustments to these and other current tax and benefit arrangements (Adam *et al* 2012, Table 5).

Another option is the reform of attendance allowance by aligning it with personal budgets and limiting new recipients to those in receipt of pension credit, which could release almost £3 billion by 2026 (Humphries *et al* 2010). In terms of other new taxation, a new hypothecated inheritance tax of 5 per cent on estates in the United Kingdom worth more than £25,000 would yield just under £3.5 billion in 2010/11. Alternatively a flat-rate charge of £20,000 on estates worth more than £40,000 could raise £4.8 billion (Lloyd 2012).

Table 5 Options for funding social care

Option	Yield
Impose National Insurance Contributions on employment income of pensioners	£0.8 billion
Only give winter fuel payment and free TV licences to those on pension credit	£1.4 billion
Impose capital gains tax at death	£0.6 billion
Reduce generosity of tax-free lump sum in pensions	£2.5 billion if abolished altogether
Impose national insurance contributions on pension income	£350 million per percentage point
Restrict tax relief on pension contributions to basic rate	£7 billion, assuming no change in behaviour

Source: Adam *et al* (2012)

The key point here is that there are options and choices about where the money could come from to fund a decent system of care and support. Most will be deeply contentious and involve trade-offs of various kinds. Care should be exercised in diluting the improvements enjoyed by older people through investment in universal benefits over the past decade. But in essence the choices are about the relative priorities given to competing demands on public spending, not the absolute affordability of good care. The implementation of the Dilnot proposals will establish a framework in which the costs of individual care are shared in a transparent way, and it opens up the possibility of a different debate about the source of funding, both private and public.

A second major issue for the next stage of funding reform concerns the relationship between the social care system and the NHS. Here, too, there is a structural fault line in the government's approach, which sees the NHS protected from a real-terms cut in its total budget throughout the Spending Review period and probably beyond, whereas local government is facing reductions of around 33 per cent in financial support from central government. Since adult social care forms the single largest controllable area of local authority spending, it is impossible to completely protect social care from cuts despite the additional resources notionally allocated for social care in the Spending Review. The local authority budget settlement is beginning to have an adverse effect on NHS organisations (Appleby 2013; NHS Confederation 2012). The issue here is not to use the NHS budget to bail out social care – ‘robbing Peter to pay Paul’; rather, it is to move towards a single, strategic assessment of the funding needs of the NHS and social care and a stronger focus on achieving better outcomes through aligning and integrating budgets around the needs of patients and service users at CCG and local authority level. The whole-place community budget pilots offer important opportunities to take this forward (National Audit Office 2013).

A third major issue for the reform of social care – and perhaps the most fundamental of all – is to be clear about the kind of system that we are trying to fund. The ambitions of the *Caring for our Future* White Paper and the Care Bill take us further towards a new model that:

- is driven by promoting independence rather than reacting to crisis

- reduces the need for formal services by promoting wellbeing and strengthening the capacity of individuals, families and communities to self-care
- addresses mounting concerns about the quality of care and how dignity and safety can be assured and safeguarded
- gives priority to enabling people's recovery after illness or accident (including re-ablement, intermediate care and telecare)
- offers people choice and control through personalised approaches and access to personal budgets
- offers good advice, information and assessment to all, irrespective of their financial means.

These are the right developments. But with increasing levels of dementia, disability and long-term health conditions, they may not be sufficient to overcome the fragmentation and over-reliance on hospitals and care homes of the current system. This is particularly the case as more people will need long-term support rather than single episodes of acute care. As traditional demarcations between health and care needs become untenable, a separate reform programme for care and support will not be sufficient; a bolder and more joined-up approach will be needed. The role of local government through its new public health responsibilities will be crucial in tackling the underlying causes of ill health and reducing future demand for health and care services.

As the next general election draws closer, the proposals outlined by the Shadow Secretary of State for Health for 'whole person' care will attract increasing interest (Burnham 2013). These propose moving towards a fully integrated model of health – physical and mental – and social care. They invite the question of whether social care should be funded through a 'voluntary' arrangement, based on a Dilnot capped cost approach, or an 'all-in' arrangement where care costs are covered in a more universal way, similar to that of the NHS. The mechanism through which this would be funded has yet to be specified but is consistent with the option put forward by the previous government for a national care service that is free at the point of use (HM Government 2010). Emerging thinking from the Labour Party's review will help to shape the debate about future policy options and choices (Health and Care Policy Commission 2013).

In the meantime, building on the framework offered by the Dilnot proposals, attention should now focus on four key priorities that together would act as a roadmap for social care reform.

- The immediate priority is the detailed preparation and planning for the implementation of the government's decisions on funding reform, recognising this will involve substantial additional responsibilities and a completely different role for local authorities. Particular importance should be attached to supporting people with their own resources, where inadequate funding is not the issue, to secure good outcomes.
- Immediate pressures on social care budgets, and their impact on the NHS, should be recognised in the Spending Review for 2015/16. There should be a move towards a single strategic budget settlement for both services and renewed efforts to drive through closer alignment of local authority and CCG budgets around individual needs.
- Health and wellbeing boards should play a key role in driving forward the transformation of social care. They should work to ensure that, through the opportunities offered by the Care Bill, this forms part of a wider transformation of local health and care services, alongside public health strategies to reduce future levels of illness and disability.
- There needs to be fresh debate about the options for funding the quantity and quality of care that society will demand in the future, recognising that the NHS and long-term

care are likely to absorb a bigger share of GDP and that anomalies in the way the two services are funded now will not be sustainable. The King's Fund will shortly announce a fundamental review of the way that health and social care entitlements, benefits and funding are organised.

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A graduate of LSE, Richard's professional background is social work, and over the past 35 years he has worked in a variety of roles, including as a director of social services and health authority chief executive (the first combined post in England) and in senior roles in the Department of Health. Richard is a columnist for the *Local Government Chronicle*, a non-executive director of Housing21 and co-chair of the associates' network of the Association of Directors of Adult Social Services. He is also a Fellow of the RSA.

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