

Commission on the
Future of **Health** and
Social Care in England



Background paper

Options for funding care

James Lloyd

Chair: **Kate Barker**

The King's Fund
11-13 Cavendish Square
London W1G 0AN
Tel 020 7307 2400

Registered charity: 1126980

www.kingsfund.org.uk

Options for funding care

James Lloyd
Director, Strategic Society Centre

This paper was commissioned by the independent Commission on the Future of Health and Social Care in England.

The views in this paper do not necessarily represent the views of the commission or of The King's Fund.

Contents

1	Introduction	4
2	The social care system	5
3	Taxation and tax relief	11
4	Universal public spending on older people	17
5	Private financial products	24
6	State-sponsored insurance schemes	33
	References	34

1 Introduction

Background

The UK population is ageing, and demand for publicly funded health and social care services is widely projected to rise in coming decades, prompting debate on how public and private expenditure on health and social care can be maintained at adequate levels. Simultaneously, there is renewed interest in the integration of the funding, commissioning and provision of health and social care services, and awareness that future decisions around how to fund social care will determine the path of health and care integration in coming years.

Scope of this paper

This paper identifies and evaluates a range of potential sources of revenue to fund expenditure on social care. It looks at:

- changes to entitlements in the local authority social care system
- taxation and tax relief
- universal public spending on older people
- private financial products
- state-sponsored insurance schemes.

It should be noted that the long-term care funding systems of the different UK nations are organised differently. For example:

- local authorities in Scotland do not undertake means testing in determining entitlement for support for personal care costs
- Welsh local authorities cap the weekly amount individuals can be charged for care and support services.

The focus of this paper is the social care system in England only.

Evaluating different options

The different funding options set out in this paper are evaluated using several criteria:

- suitability – how much revenue would be brought into the social care system on an annual basis, whether via public spending or private expenditure?
- feasibility – what are the policy and regulatory changes or costs required for implementation, and how feasible and sustainable are they? What would be the consequences for other areas of public policy?
- acceptability – will the public understand it and support it?
- equity and fairness – does it treat different groups fairly and consistently?
- integration – does it help or hinder potential measures to integrate the health and care commissioning, funding and delivery?

2 The social care system

Introduction

Some commentators argue that the funding challenge confronting the health and care systems in England can be met by improving the way in which existing resources are spent. This could take the form of:

- transferring resources directly from NHS budgets to local authority expenditure on social care
- saving money through reforming service design, such as integrating health and social care services to reduce assessment costs
- investing in cost-effective preventative interventions, such as falls prevention.

These options fall outside the scope of this paper and are not examined here.

However, a further way in which resources could be 'found' within existing public spending on social care is through changing the rules and configuration of local authority needs and means assessments, which determine entitlement to support.

This chapter reviews these options.

Integration

It should be noted that any changes to current rules on means and needs assessments in the social care system would have consequences for the future integration of health and social care commissioning, funding and delivery. However, the precise nature of these consequences would depend on how local authority support for care costs was being reconfigured, and on policy design choices around integration.

Changes to entitlements and financial profile of the target population

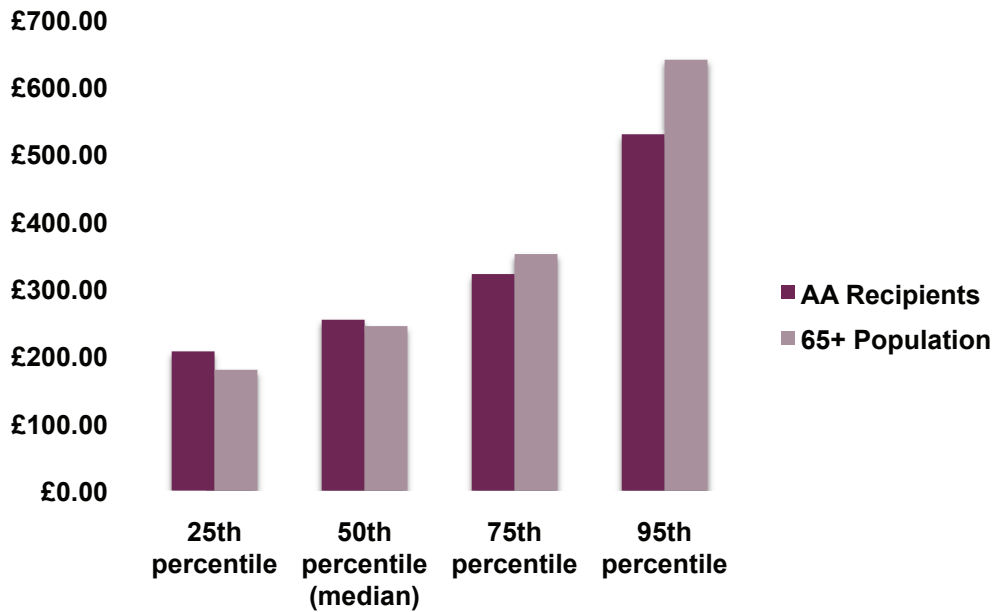
In order to evaluate the scope for individuals to pay more for social care, whether by scaling down local authority entitlements or increasing charging, it is useful to map the distribution of income and wealth of the population most likely to be affected by such changes.

No data is available on the income and wealth of local authority care users specifically. However, the best 'proxy group' are the more than one million people in England in receipt of Attendance Allowance (AA – see chapter 4 for a full description). The following charts set out their financial position, and that of all individuals aged 65 in England, for 2010 (Lloyd and Ross 2013).

Equivalised total weekly income

The median equivalised income of AA recipients in England was £253.48 a week in 2010. This includes the value of AA.

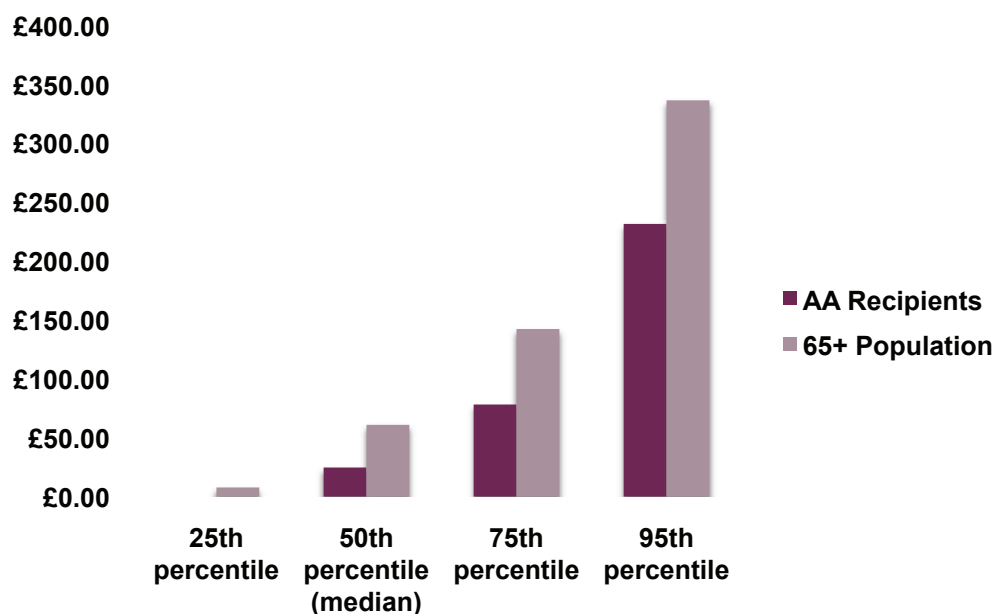
Equivalised total weekly income, AA recipients and the 65+ population



Equivalised annuitised weekly income (private pensions and other annuity)

In addition to AA and the state pension, the income of an AA recipient may also include private pension income. However, a notable feature of AA recipients is very low levels of private pension income, compared with the general 65+ population. Indeed, the median private pension income of AA recipients is less than £25 per week, and 25 per cent of AA recipients are in receipt of means tested Pension Credit.

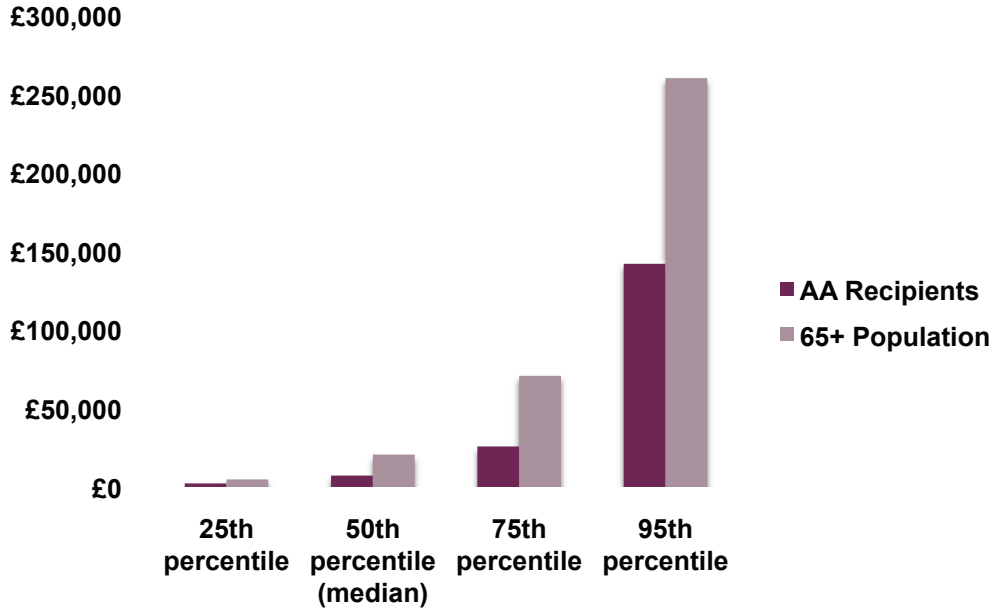
Equivalised annuitised weekly income, AA recipients and the 65+ population



Net financial wealth

Turning to financial wealth (savings, investments, equities, etc), median financial wealth among AA recipients is slightly more than £7,000.

Net financial wealth, AA recipients and the 65+ population

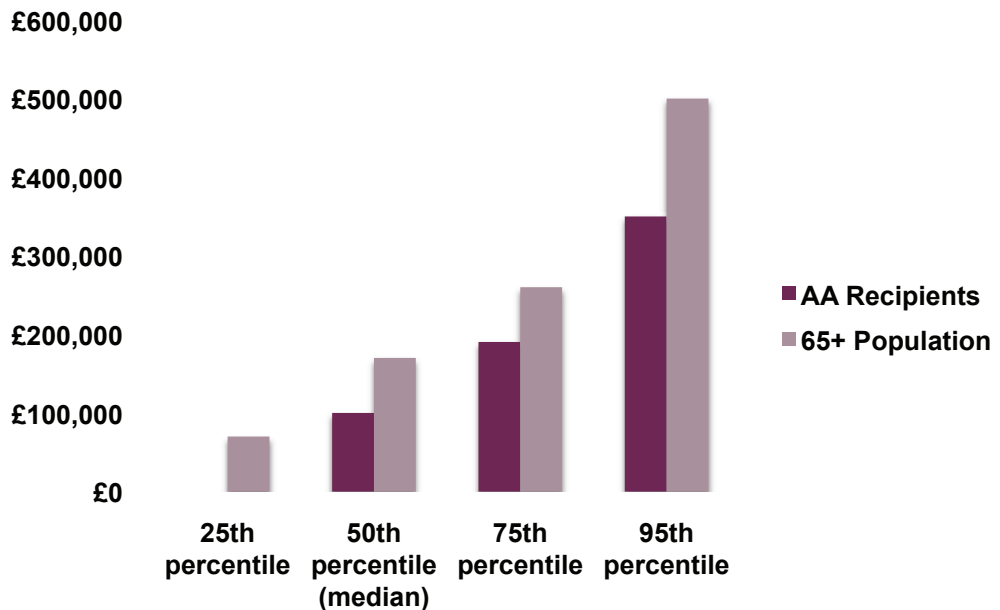


Nevertheless, as with income, the most well-off AA recipients are notably richer. The wealthiest 5 per cent of AA recipients (around 65,000 people) had £141,000 or more of financial wealth in 2010.

Net housing wealth

Half of AA recipients had a total of £100,000 of housing wealth or less.

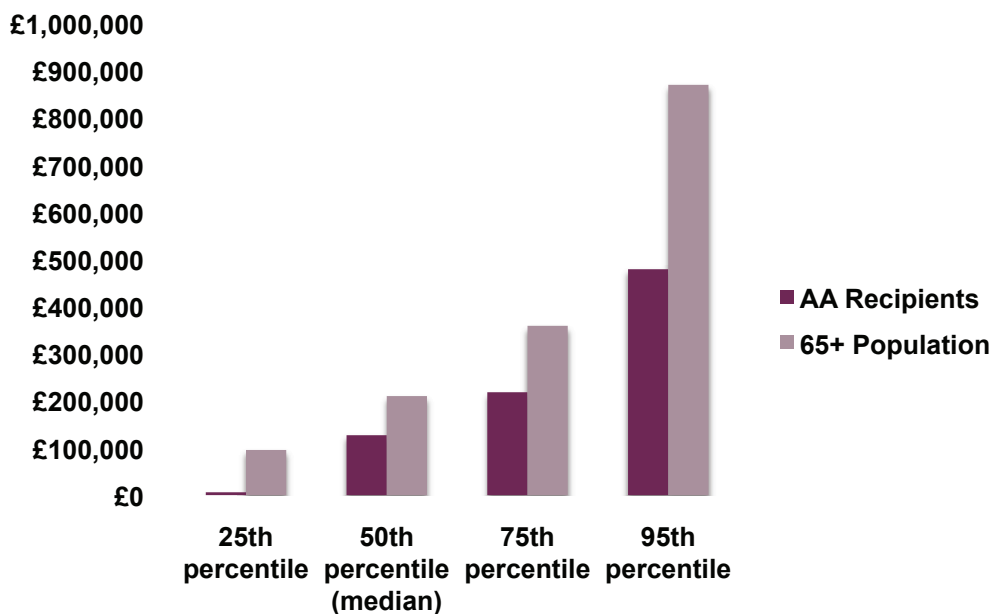
Net housing wealth, AA recipients and the 65+ population



Net total wealth

Reflecting the major role of housing wealth in total household wealth, the distribution of wealth among the poorest 75 per cent of AA recipients is very similar to the distribution of housing wealth.

Net total wealth, AA recipients and the 65+ population



Changes to rules on means testing: 'assessable wealth'

Local authority support for the costs of care is proportional to someone's financial means. However, the value of most people's largest asset – their home – is not classified as assessable wealth in the means test for *domiciliary care* applied by local authorities in England. Therefore individuals can be entitled to substantial amounts of public support for the costs of home care, despite owning a very expensive home, if their income and liquid savings are sufficiently low. In contrast, individuals in *residential care* who own a home without any partner or dependent living in it will be expected to pay for the full cost of their care.

This can result in outcomes that some feel are anomalous, and even inequitable.

- Two people can have very similar levels of disability and wealth, but one may be forced to pay for their care and the other not, if one happens to receive care in their own home and the other in a care home.
- The current treatment of property in the means test for home care encourages local authorities to nudge individuals into residential care as early as possible so that they become responsible for paying for their own care.

Importantly, there is wide variation in the prevalence of individuals in residential care across England, largely because of geographical variations in the supply of residential care places.

In this context, for reasons for fairness and public expenditure, it has been suggested that rules on property and assessable wealth for home care should be more closely aligned with those of residential care.

Projections by the Personal Social Services Research Unit (PSSRU) estimate that if people's homes were included in the means tests for domiciliary care, the number of council-funded home care users would be significantly reduced to 145,000 in 2010 and 190,000 in 2030 compared with 285,000 in 2010 and 485,000 in 2030 under the current system. This would represent a saving to social services of **around £1.2 billion in 2010 rising to £3.4 billion in 2032** at constant 2010 prices (Wittenberg *et al* 2011).

However, if homes were included in the means test for domiciliary care, it is likely to require the extension of local authority deferred payment schemes (ie, council loans for care costs against the value of a person's property) to individuals receiving home care, and this would result in some offsetting costs.

Pros

- Savings to local authorities.
- Removes incentives for local authorities to nudge people into residential care.
- Equity and fairness between individuals in domiciliary and residential care.

Cons

- Unmet need – some individuals who did not qualify for financial support for home care because of the value of their home would, particularly given liquidity constraints, be unlikely to buy care privately, and would therefore experience unmet need, which would potentially result in higher, downstream costs for the NHS. Although the availability of local authority deferred payment schemes for domiciliary care may partially prevent this, widespread aversion to debt would probably inhibit some households from making use of such a scheme.
- Fairness – although applying the same means test rules for property wealth across home and residential care would improve fairness, there would still be an inequity between home care users who live with a partner/child and those who live alone, unless the property wealth of those cohabiting was also brought into the means test as assessable wealth.
- Incentives to engage in 'deliberate deprivation' – if homes were included in the local authority means test for home care support, this would incentivise more families to attempt to pass the means test by transferring ownership of property to children.

Changes to rules on means testing: tariff income ratio

For the purposes of local authority means tests, assessable wealth is converted to tariff income using a ratio of £250 of wealth as equal to £1 of income per week. Reducing this ratio, for example, to £100: £1, would reduce costs to local authorities and increase charges paid by individuals.

Pros

- Expenditure – increasing the scope of charging would reduce costs to local authorities.

Cons

- Such a move would also increase the speed at which individuals reduce their wealth.

Changes to rules on means testing: changes to capital limits

At present, local authority means tests comprise two capital limits in relation to what is counted as assessable wealth for the purposes of the means test:

- an upper capital limit of £23,250
- a lower capital limit of £14,250.

The government has announced that the upper capital limit for residential care in England will increase to £118,250 from April 2016 as part of the implementation of its capped cost reforms, with both capital limits subsequently uprated for inflation on an annual basis.

Reducing the level of these capital limits, freezing them or uprating them below the rate of inflation would reduce the generosity of local authority support, but would also lower costs to local authorities.

Changes to eligibility thresholds: restrict eligibility

Local authorities in England apply a needs assessment to determine eligibility for support, which uses a framework called fair access to care services (FACS) comprising four levels: low, moderate, substantial and critical. The government has announced that in future all local authorities must set their eligibility threshold at 'substantial'. However, raising this to critical would reduce costs to local authorities, albeit accompanied by greater levels of unmet need and follow-on costs to the NHS.

3 Taxation and tax relief

Introduction

This chapter considers various options to fund social care in England based on changes to taxation and tax relief that have featured in debate on the future of care funding.

In truth, any number of hundreds of changes to the tax system could be used to derive revenue for the care system. However, echoing debate on social care funding in England and accompanying concerns around 'intergenerational fairness', this chapter principally focuses on taxes affecting older cohorts, particularly involving housing wealth.

The options considered involve change to:

- general taxation
- pensioner income tax thresholds
- capital gains tax on primary homes
- national insurance contributions
- inheritance tax
- pension tax relief.

Several preliminary points should be made.

UK versus English policy-making

Taxation-based options to fund social care in England are complicated by the fact that tax policy is mostly set by the Westminster government at the level of the UK. This raises a number of questions for the options set out below. For example: would a new inheritance tax threshold to fund social care in England apply across the whole of the UK?

Ringfencing

Given public resistance to new forms of taxation, it has been suggested that new taxes, or substantial changes to tax rates related to funding social care, should be ringfenced to improve the chances of public support, ie, the revenue generated should be allocated solely to public expenditure on social care with an appropriate label attached to the new tax rate, such as 'care levy'.

HM Treasury has traditionally resisted ringfenced taxes, which reduce the scope of the available tax base over which it has discretionary control for fiscal policy-making.

It is also important to note that any new ringfenced tax would generate only part of the revenue for public spending on health and social care in England – with a large proportion, as now, continuing to come from general taxation. Therefore strict ringfencing of new tax revenue for social care is impossible, since HM Treasury would retain control over the remaining tax revenue allocated to social care, which it could raise or lower in response to changed political priorities and variations in the revenue derived from a ringfenced tax.

Integration

The options for changes to taxation and tax relief set out below are all coherent with future policy choices around the integration of health and social care in England. The only caveat to this is that using ringfenced taxes to fund social care may be difficult if policy-makers subsequently decide to merge all social care and health spending and budgets.

General taxation

Additional public spending on social care could be derived from general taxation.

Pros

- Acceptability – simple and understandable to the public.

Cons

- Feasibility – projections of future public spending and taxation revenue (Office for Budget Responsibility 2013) suggest this approach would be unsustainable without significant cuts to other areas of public spending.
- Equity – the largest sources of government revenue – income tax (25.5 per cent), national insurance contributions (17.9 per cent) and, to a large extent, VAT (17.2 per cent) (Browne and Roantree 2012) – come from working-age cohorts. This has raised questions around the fairness of imposing additional tax burdens on younger cohorts to maintain social care entitlements largely directed to older households.

Pensioner income tax thresholds

The 2013/14 personal allowance for income tax is £9,440 for the under-65s, £10,500 for 65–74-year-olds and £10,660 for the over-75s.

Through reductions or freezing, the value of the personal allowance for pensioners could be brought into line with working-age individuals.

Only around 15 per cent of older people currently pay basic rate income tax, and around 8 per cent pay higher rate (according to a government response to a Freedom of Information request from Age UK). Lowering the personal allowance for pensioners in England in 2013 to £9,440 would therefore raise around £1.5 billion per year (author's calculation).

Pros

- Equity – income tax is progressive, and there is limited rationale for the higher personal allowance for pensioners.

Cons

- Acceptability – any direct cuts to the pensioner personal allowance may generate public hostility (eg, 'granny tax').

Capital gains tax on primary homes

The rate of owner-occupation among those aged 65+ in England is relatively high – around 75 per cent (Lloyd and Ross 2013) – and will increase over the next two decades as the babyboomer cohort becomes the principal cohort comprising the pensioner age group.

Under current rules, capital gains tax does not apply to primary homes, and the windfall of wealth accruing to older households owing to above-inflation price increases in the value of residential property over recent decades will remain untaxed.

In this context, it has been proposed that there should be a capital gains tax on primary homes – potentially ringfenced – to provide additional revenue for the social care system.

The annual revenue that would come from such a tax would depend on rates of house sales across the economy, the extent of capital gains on primary homes experienced by households, and the thresholds and rates levied. For second homes, capital gains tax is currently between 18 per cent and 28 per cent for individuals.

If appropriate, capital gains tax on primary homes could be levied only on specific groups, such as pensioners or the deceased.

Pros

- Suitability – depending on choices around tax rates, the revenue generated could be significant, from a source that is currently untaxed.

Cons

- Feasibility – may deter older home-owners from moving home, with implications for downsizing, the distribution of the housing stock, and the revenue generated from the tax.
- Acceptability – any proposals for capital gains tax on primary homes have traditionally been met with public opposition.

National insurance contributions

Individuals over the state pension age with employed or self-employed income do not pay national insurance contributions (NICs). Using the 2007/8 Survey of Personal Incomes and Office of Budget Responsibility (OBR) assumptions on estimated changes in behaviour, HM Treasury has estimated that the introduction of employee NICs for this age group would have raised around £500 million in revenue for 2011/12.

Pros

- Acceptability – simple and understandable – although may generate hostility as a ‘pensioner tax rise’.

Cons

- Effect on labour market participation – reduces incentives for those at retirement age to keep working, in direct contradiction of government policy to extend working lives and encourage pension contributions for longer.

Inheritance tax

Estates worth more than £325,000 on death are taxed at a rate of 40 per cent above this threshold.

The coalition government has announced that to fund the cost of the 'capped cost' reforms to care funding in England to be introduced in April 2016, the extra £1 billion cost of the reforms by 2020 will be met:

...in part by freezing the inheritance tax threshold at £325,000 for a further three years from 2015/16...[and] the remaining costs over the course of the next Parliament will be met from public and private sector employer national insurance contributions revenue associated with the end of contracting out as part of the introduction of the single-tier pension.

(Hansard 2013)

However, in addition to freezing inheritance tax thresholds, there are many additional options for using inheritance tax to derive extra revenue for the social care system in England.

Any new inheritance tax to fund social care in England would confront a number of design choices (Lloyd 2011c):

- thresholds for the tax and the rate it is levied at
- whether to ringfence the new rate in order to secure greater public acceptance
- whether to cap ringfenced tax bills, eg, to prevent a 'care levy' on an individual estate of £100,000
- incidence by age of death, eg, applicability to the estates of those who die under the age of 40
- incidence by asset type – inheritance taxes could apply to some assets but not others, eg, housing wealth but not liquid savings. This is important; of the £61.4 billion left in estates during 2008/9, around £30 billion worth was UK residential buildings. Of 272,000 estates, 168,136 included residential property wealth, the average gross value of which was £178,230 (HM Revenue & Customs 2011).

The revenue generated by changes to inheritance in the UK would depend on choices around thresholds and rates. To provide an illustration, it has been estimated that a 13 per cent inheritance tax on estates worth more than £25,000 would generate around £6.5 billion per year (Lloyd 2011a).

Pros

- Feasibility – could be handled by existing probate system.
- Acceptability – simple and understandable.

-
- Scope to generate revenue – depending on policy choices, inheritance taxes could generate significant amounts of new revenue.
 - Equity across generations – the incidence of additional inheritance taxes mostly falls on the estates of older people, rather than the wealth of younger households.
 - Equity within generations – value of ‘contributions’ under inheritance tax are proportional to wealth.
 - Suitability – if older households are to make additional tax contributions to fund the social care system, it is arguably preferable for these contributions to be derived from their housing wealth, rather than income or savings that are better used to fund consumption that contributes to better health outcomes.

Cons

- Acceptability – inheritance taxes have traditionally been unpopular with the public.
- Feasibility – uncertainty around response by households to new inheritance tax thresholds and extent of tax evasion.
- ‘Carer penalty’ – any new inheritance tax would fall on the estates of those whose care and support needs were met entirely by family members rather than the state, sometimes over the course of many years, which may be seen as unfair to family carers.
- Feasibility – revenue streams from inheritance tax are highly sensitive to fluctuations in house prices, and a number of factors would drive variations from year to year, ie, the revenue stream would be ‘lumpy’.

Pension tax relief: contributions

Individuals making contributions to a private pension do so before their income has been taxed. The government announced in October 2010 that from 2011/12 the annual allowance for tax-privileged pension saving will be £50,000 and that from April 2012 the lifetime allowance will be £1.5 million. Together the changes are projected to generate around £4 billion a year (HM Treasury 2010a).

Some have proposed lowering the annual allowance even further, for example from £50,000 to £30,000, with the additional revenue saved directed to the social care system. Previous analysis by HM Treasury has estimated that this would generate around £1 billion per year (HM Treasury 2010b)

Pros

- Equity – limits to pension contributions primarily affect higher income individuals.

Cons

- Feasibility – critics of cuts to pension tax relief note many pension schemes are effectively subsidised by charges on large contributions

by higher earners. Therefore cuts to pension tax relief and subsequent reductions in the value of contributions from higher income individuals may push up average charges for lower income workers.

- Financial planning – cuts to the annual allowance penalises those who make periodic large contributions to their pension schemes, for example, upon the sale of a business or getting an inheritance.

Pension tax relief: 25 per cent lump sum

At present, individuals can take 25 per cent of the value of their accrued pension as a tax-free lump sum payment at any time from the age of 55 onward. Such income is therefore entirely untaxed. HM Revenue and Customs (HMRC) has estimated that this relief is worth a total of £2.5 billion a year under the assumption that this income would otherwise have been taxed at the basic rate (cited by Adam *et al* 2012). In future, this tax-free lump sum could be scrapped and the additional tax revenue directed to the care and support system

Pros

- Equity – current rules regarding the 25 per cent lump sum actually grant it the most generous tax relief of any form of saving in the UK.

Cons

- Incentives – the prospect of being able to take a 25 per cent lump sum payment from the age of 55 may act to incentivise some individuals to save for retirement, as well as overcome the concerns of some savers regarding locking away their pension saving for many years.
- Financial planning – any change would be disruptive to those who already have specific plans for using their 25 per cent lump sum.

4 Universal public spending on older people

Introduction

Projections of rising demand for publicly funded social care mostly reflect the ageing of the population. Simultaneously, older households in the UK are characterised by wide – and unprecedented – inequalities in income and wealth.

This has led some commentators to question the appropriateness of universal entitlements for older people paid for through public spending, with some suggesting that changes to universal entitlements could be used to fund additional future spending on social care in England.

This chapter identifies and reviews such entitlements and explores what revenue could be made available for the social care system through reconfiguring universal entitlements, for example, increasing age thresholds.

Means testing

The most frequently suggested option for configuring older people's universal entitlements is means testing. Three principal options for means testing can be identified:

- higher rate income tax – reducing entitlements to pensioners paying this tax
- basic rate income tax – reducing entitlements to pensioners paying this tax
- Pension Credit – restricting entitlements to those receiving Pension Credit.

However, these forms of means testing for any universal entitlement present significant challenges which are worth clarifying at the outset.

Problems with means testing

As noted above, higher rate income tax is only paid by around 5 per cent of pensioners, and basic rate income tax is paid by around 15 per cent. Therefore means testing universal entitlements for pensioners via the income tax system would only:

- affect a relatively small number of people, with consequences for potential revenue that can be raised
- consider a person's income, rather than wealth. Universal entitlements would continue to be paid to pensioners with high levels of liquid and illiquid assets (housing, savings, etc) but who do not pay income tax.

In relation to means testing via the Pension Credit system, multiple problems can be identified.

Take-up of means tested Pension Credit

The Department for Work and Pensions (DWP) estimates that take-up of Pension Credit – the means tested income support for pensioners – is between

62 per cent and 68 per cent (DWP 2012). This suggests around 1.3 million pensioners in the UK living in poverty do not receive Pension Credit. So using Pension Credit to means test universal pensioner entitlements would mean taking these entitlements away from the poorest 1.3 million pensioners.

Acceptability

Means testing of Pension Credit is resented by older people, so any increase in the scope of means testing would probably be unpopular and resisted.

Retirement saving incentives

Any form of means testing in retirement undermines incentives to save for retirement: if individuals save, they may disqualify themselves from entitlements they would have otherwise received. Although the actual effect of retirement means testing on pension saving behaviour is unclear, the stated objective of DWP is that it must 'pay to save', and the government's single-tier pension reforms – described below – seek to achieve this.

Scaling down of Pension Credit and accompanying means-testing infrastructure

The government has committed to introduce the single-tier pension from April 2016, which will ultimately significantly reduce the number of people entitled to Pension Credit and the need for a means-testing system to allocate it. As such, it will be increasingly unfeasible for Pension Credit to be used to means test other entitlements.

Integration

It is worthwhile noting that, with the exception of changes to Attendance Allowance, none of the options considered here have implications for the potential future integration of health and social care.

State pension

The state pension comprises a core, universal pension and means tested top-up payment (Pension Credit) for those with a low private pension income. The value of the basic state pension is £110.15 a week for an individual, but through Pension Credit all pensioners are guaranteed to have an income of at least £145.40 a week.

Public spending on the state pension was £74.1 billion in 2011/12, and the cost of Pension Credit was £8 billion (DWP benefit expenditure tables). The government has committed to uprate the value of the state pension by the 'triple lock', ie, in line with the highest of either the increase in Consumer Prices Index or earnings, or 2.5 per cent, to 2015.

Single-tier pension

In addition to the 'triple lock', the government has committed to phasing out the current basic state pension to replace it with the single-tier pension for those retiring after 6 April 2016 (DWP 2013). Entitlement to the single-tier pension

will require more years of qualifying earnings, but its level will be set higher, at around £144 a week in today's prices.

The aims of this reform are:

- simplicity – it replaces and simplifies many of the rules that currently determine eligibility for the state pension
- reduction of means testing – over time, most retirees will receive the single-tier pension which, because it is set above the level of Pension Credit, will significantly reduce the extent of means testing in the older population
- incentives to save for retirement – by ensuring that most workers are – through adequate contributory years – guaranteed a decent, adequate state pension in retirement, the single tier pension significantly improves incentives to save for retirement, compared with the current regime.

To fund this higher state pension, the government is closing the state second pension, and contracting out of the state second pension for defined benefit schemes will come to an end. The single-tier pension will actually cost less in the medium to long term, and the government has already allocated some of these savings to fund some of the additional costs imposed by the 'capped cost' reforms to care funding in April 2016.

It is also worth noting that as retirees in receipt of the single-tier pension begin to enter the social care system, roughly around 2026, the pension income of individuals with private pension saving (who previously would only have received the old basic state pension) will be higher, marginally increasing their ability to contribute toward their care costs.

Nevertheless, in the context of the single-tier pension, the government has two broad options to redirect public spending into the social care system.

Freeze or uprate below the rate of inflation

The single-tier pension represents a major, fundamental reform to the architecture of the UK's pension system, seeking to ensure that the state pension represents a decent, adequate income for all pensioners who receive it.

However, notwithstanding these aims and other reforms in progress, freezing the single-tier pension or uprating it below the rate of inflation would reduce its cost, potentially releasing public spending that could be transferred to the social care system.

Raise state pension age

The state pension age, which is currently 65, will increase to 66 by 2020 and subsequently to 67 between 2026 and 2028.

Bringing forward increases to the state pension age would save a considerable amount.

The National Institute of Economic and Social Research (NIESR) has estimated that an increase of one year in the effective retirement age would save the government around £13 billion a year (Barrell *et al* 2009). However, as NIESR notes, given the labour market participation rate of workers around retirement age is below 100 per cent, this requires an increase in the effective state pension age of more than one year to generate such savings.

Pros

- Revenue – raising the state pension age by just one year would generate considerable amounts of revenue in the context of the social care system in England.

Cons

- Acceptability – increases to the state pension age are relatively unpopular.
- Fairness – in order to allow individuals to engage in long-term financial planning for their retirement, increases to the state pension age need to be announced many years ahead. Some people might feel additional increases to the state pension age should not be introduced ahead of 2026, which would delay considerably the availability of any additional revenue for the social care system.

Attendance Allowance

Attendance Allowance (AA) is a weekly cash payment, administered and paid by the Department for Work and Pensions (DWP), to individuals aged 65 or over in the UK who need help with personal care or have difficulties with activities of daily living because they are physically or mentally disabled.

In 2013/14, AA was paid at a lower rate of £53 per week and higher rate of £79.15 a week. According to DWP administrative data, in August 2012 there were around 1.5 million people in the UK receiving AA. According to the DWP, the cost of AA in England in 2011/12 was £4.46 billion.

Eligibility for AA is not determined by financial means, or the availability or receipt of formal or informal care. Recipients are free to spend the money as they want. This reflects the underlying rationale of AA as a contribution to the extra costs of living with a disability.

Means testing Attendance Allowance via Pension Credit

The Wanless Social Care Review, undertaken for The King's Fund in 2006, argued that AA could be more efficiently allocated by restricting entitlement to pensioners on means tested income support (Wanless 2006). The review team proposed redirecting the revenue saved into the social care system to fund more generous local authority entitlements, incorporating 'matching contributions' (the 'Wanless partnership model').

Subsequently, The King's Fund and PSSRU calculated that if in future only recipients of Pension Credit were allowed to begin claiming AA (while existing claimants continued to receive it) the savings to public expenditure in 2010 terms would be as shown in Table 1.

TABLE 1: Potential savings if new AA claimants were means tested

£ billion	2015/16	2020/21	2025/26
AA	4.17	4.41	5.13
Means tested AA	3.35	2.37	2.18
Savings	0.82	2.04	2.95

(Humphries *et al* 2010)

By 2020, means testing AA for new applicants would save around £2 billion per year.

Pros

- Equity – targets AA expenditure at lowest income households.

Cons

- Problems with means testing – AA would not reach the poorest pensioners who fail to claim AA.
- Suitability – by definition, older people in receipt of AA confront higher everyday costs owing to living with a disability, so their income poverty threshold is actually higher than the level of income guaranteed under Pension Credit, raising questions around whether this is a suitable threshold for use in means testing of such groups.
- Opportunity cost – as described below, there are considerable opportunities to extract greater value for money from public expenditure on AA, which would be lost through means testing.

To evaluate the proposal of means testing AA, it is also worth making several further points:

- AA reaches far more people than the local authority social care system (1.3 million in England, compared with 532,000 older people receiving local authority funded domiciliary care) (Department of Health 2012)
- there is substantial non-overlap between recipients of AA and recipients of local authority support (Lloyd 2013b)
- AA recipients are typically poorer than average, so associated public spending is already targeted to some extent. For example, median annuitised private pension income among AA recipients is £25 per week (Hancock *et al* 2010)
- given substantial non-overlap, it has been suggested that to some extent the AA and local authority support systems stem demand for each other, as a result of various factors (Lloyd 2013b): potential demand effects on local authority support from means testing AA should not be discounted.

More widely, analysis by the Strategic Society Centre has identified a number of potential reform options for AA which would significantly enhance its value for money in the context of health and care spending (Lloyd 2013b). These include:

- data-sharing – opportunities presented by the DWP sharing with other agencies the data it collects to process AA assessments

-
- information and advice – the potential for providing information and advice to AA recipients
 - supporting ‘independence behaviours’ – the opportunity presented by AA to influence the behaviour of recipients and those supporting them.

In addition to means testing, there are various other ways to restrict entitlement to AA to release resources that can be transferred to the social care system.

Freezing the value of Attendance Allowance

If the value of AA was frozen – ie, not uprated with inflation – the savings to the DWP have been estimated to be around £790 million by 2020/21, assuming a 2 per cent inflation rate (Lloyd 2012).

Means testing Attendance Allowance via income tax

AA could also be means tested by making it liable for income tax. Alternatively, receipt of AA could be restricted to only pensioners who do not pay income tax. However, as described above, around only 15 per cent of pensioners pay income tax, and median private, equivalised pension income of AA recipients is around £25 per week (Lloyd and Ross 2013), suggesting such a measure would raise only around £100–£200 million in England.

Winter fuel payments

According to the Office for National Statistics (ONS), the number of preventable excess winter deaths in England and Wales during 2011/12 was around 24,000 (ONS 2012), the vast majority of whom were pensioners. It has been estimated that the annual cost to the NHS in England of cold-related illness arising from cold homes is £1.36 billion (Age UK 2012).

The winter fuel payment is a non-means-tested tax free cash payment worth between £100 and £300, depending on the person’s circumstances, to ‘help pay ...heating bills’. The value of the winter fuel payment depends on a person’s age, whether they receive any means-tested benefits and whether they live with someone else who also qualifies for it. It cost £2.15 billion in 2011/12, and was paid to around 12.7 million people in the UK.

It appears that around two-fifths of the value of winter fuel payment is spent on fuel. Using social survey data on household expenditure, the Institute for Fiscal Studies (IFS) found robust evidence of a substantial ‘labelling effect’, estimating that households spend an average of 41 per cent of the payment on fuel (Beatty *et al* 2012). If the payment was treated in an equivalent manner to other increases in income, the expected household expenditure on fuel would be 3 per cent. This suggests the £2.15 billion cost of payments in 2011/12 resulted in £0.817 billion of extra spending on fuel by recipients that would not have been achieved, for example, by an equivalent increase in the value of the state pension (Lloyd 2013a).

Winter fuel payment could be reconfigured in various ways to lower its cost, in order to release funding for the social care system. Options include:

-
- scrapping the payment – saving the Exchequer £2.1 billion a year, but potentially reducing spending on fuel by older households by as much as £817 million each year
 - means testing payments via the Pension Credit, potentially raising around £1.2 billion (Lloyd 2012)
 - raising the age threshold to 70, below which the incidence of excess winter deaths is lower, saving £350–600 million each year (Lloyd 2013a)
 - converting the payment to an 'opt-in' benefit (but risking older households not claiming and cutting their fuel expenditure)
 - reclassifying payments as part of the state pension, so public expenditure on the state pension can be cut by an equivalent amount, thereby releasing revenue.

Although such measures would potentially derive revenue that could be allocated to the social care system, there are a number of drawbacks:

- any loss or reduction in the value of winter fuel payment would probably reduce older people's fuel expenditure, with potential consequences for the preventable excess winter deaths and the cost of cold-related illness to the NHS
- problems with means testing older people, set out above.

Over-75s TV licences

The cost of free TV licences for the over-75s in the UK in 2011/12 was around £600 million according to figures from the Department for Work and Pensions Budget Expenditure Tables (2013). Means testing this entitlement via Pension Credit would save around £150 million a year.

Concessionary travel for the over-60s

Individuals aged above 60 in England may be entitled to concessionary travel, funded by their local authority, with an estimated annual cost to the Exchequer of around £500 million (Lloyd 2012).

Expenditure on concessionary travel could be restricted in various ways, for example, raising the eligibility age from 60 to 70, or restricting eligibility to those on Pension Credit (income support) or Attendance Allowance (disability support).

Potential savings could be up to around £400 million per year.

However, particularly in the context of social care funding options, such savings would have to be offset against potential unintended costs of reduced travel among the older population and ensuing changes in lifestyle. For example, reduced travel among the older population may have consequences for:

- prevention and health services – increasing the costs of going to medical appointments may result in higher subsequent costs to the NHS
- social capital and mental health – if older people make less use of public transport, such as bus services, this may reduce their leisure activity and social contact, with implications for mental health and subsequent use of NHS resources.

5 Private financial products

Introduction

In response to demand and budget pressures on local authority social care spending in England, various commentators have proposed greater use of private sector financial products.

Three broad types of financial product can be identified in relation to social care:

- pre-funded insurance, where individuals pay premium(s) before the onset of disability, in return for which they receive a lump sum or income following a successful claim
- point-of-need insurance, bought by individuals who already have a disability and guaranteed to pay an income for life, therefore protecting individuals in relation to their care costs as they get older
- 'decumulation' products that help individuals spend their wealth to fund their care costs.

The principal criteria for evaluating the use of financial products in relation to funding care are:

- what revenue could a product reasonably be expected to bring into the social care system?
- to what extent do the products protect individuals from care costs via risk pooling?

Pre-funded insurance

Pre-funded care insurance pays out a lump sum or income to individuals who have experienced a defined level of disability (as distinct from 'care needs'), using an agreed, standardised measure of disability, such as inability to carry out one of six activities of daily living (ADL).

No country in the world has a properly functioning market in pre-funded care insurance (Lloyd 2010). Pre-funded care insurance products are not currently available in the UK, and the last provider left the market in 2010 citing a lack of demand.

This market failure in pre-funded care insurance reflects significant supply- and demand-side barriers, some of which are distinct to England. A comprehensive analysis by the Strategic Society Centre in 2010 identified the following issues (Lloyd 2010).

Supply-side barriers

- Limited profitability and market size – some providers believe the pre-funded care insurance market is never likely to be large enough to generate significant profits, making it unattractive given the considerable costs required to launch a product.
- Uncertainty posed by longevity and morbidity risk make pre-funded products particularly difficult for actuaries to price. As a result, in the

past products typically required limits on payouts or options for providers to review premiums. However, these in turn made the products less attractive to consumers.

- Possible adverse selection (a propensity for those most likely to draw on the insurance to take out a policy, thus increasing the ratio of costs to profit for the insurer).
- Disability assessments for claims assessments could not be done by GPs or social workers, as both would be incentivised to approve claims so a new disability assessment system would be required.
- Reputation risks for providers – for example, from customers unhappy that their insurance payout did not meet the typical cost of residential care at the time.
- Resistance to new brands among independent financial advisers, and the cost to them of gaining new qualifications necessary to advise on pre-funded care insurance products.
- Some independent financial advisers believe it is their role to help clients move their wealth around to ensure eligibility for local authority support for care costs, rather than to sell pre-funded care insurance.

Demand-side barriers: financial

- The cost of premiums would be unaffordable to many households, limiting market size.
- Most households have competing financial motives.
- Potential care costs are not the only possible unforeseen future costs confronting older households, so households may opt for precautionary liquid saving.
- Households have alternative strategies for paying for care, eg, 'sell the house'.

Demand-side barriers: uncertainty around what exposure is to be insured against

- Most social care is provided as informal care, and individuals may be uncertain about the future availability of informal care and consequent probability of needing paid care.
- Political risk, ie, uncertainty over political decisions around the availability and shape of state support up to several decades into the future making it uncertain what will be available when someone needs care.
- Uncertainty regarding the household's future level of wealth at the time of needing care, and therefore potential eligibility for local authority support.
- Uncertainty over future unit care costs, and how much protection is therefore required.

Demand-side barriers: knowledge

- Ignorance of the risk of needing care.
- Ignorance of what care and support is.
- Belief that all care is provided free by the state.
- Confusion relating to eligibility arising from Scotland's system of free personal care.

Demand-side barriers: behaviour

- Inertia.
- Mental discounting of the risk of needing care.

Demand-side barriers: structural barriers

- Complexity of products.
- Distrust of financial services providers.
- Obligation to obtain paid-for financial advice.
- Shortage of qualified financial advisers.
- Expectation that it will be possible to 'game' the local authority means assessment through deliberate deprivation of assets.

Estimating market-size

To estimate the level of funds that could be derived for the social care system in England through the return of a pre-funded care insurance market, it is necessary to estimate potential market size.

As described above, historically pre-funded care insurance products have involved 'capped' payouts. For the sake of a worked example, the following assumptions are therefore made:

- a £35,000 payout is triggered by a standardised measure of disability, such as experiencing three ADL failures
- the premium for such a product is £10,000 reflecting a one in three/four chance of experiencing the defined level of disability
- no individual would choose to spend more than one-third of their liquid wealth on insuring themselves
- individuals will not purchase insurance when still in employment, given the strong tax incentives to direct spare income to a pension, so the products are purchased on retirement.

According to the Office of National Statistics, around 703,000 people turned 65 in 2012. Around 25 per cent of the 65–74 age group have £60,000 in household financial wealth.

Therefore one quarter of the 703,000 individuals turning 65 would have sufficient liquid wealth to consider buying pre-funded long-term care insurance for £10,000 for themselves and their partner. This amounts to a potential

'target market' for this pre-funded care insurance product of around 175,750 people each year.

Estimating revenue for the care system

An optimistic assumption that the take-up rate among the target market is 25 per cent amounts to around 44,000 individuals, or 6.25 per cent of new retirees.

If 44,000 new pre-funded long-term care insurance policies are sold each year, and the value of premiums is £10,000, this suggests the gross revenue in this market will be £440 million a year.

If an average 10 per cent of this revenue represents profit for providers, the total profit for the whole market will be around £44 million.

If, for the sake of this worked example, it is assumed that actuarial estimates are correct, and all the payouts on all the policies bought in a single year are also made in a single year, this suggests that the annual addition revenue available for private expenditure on care derived from the operation of a pre-funded care insurance market would be around £400 million.

However, this figure reflects numerous optimistic assumptions and should be considered at the top end of what might be feasible.

Finally, it is worth noting that if it is assumed that no firm has more than one quarter of the market, then the maximum annual profit from selling pre-funded long-term care insurance would be $0.25 \times £44$ million, ie, £11 million.

Pros

- If pre-funded care insurance markets were to return in England, this would enable individuals to insure themselves against some of their future potential care costs, and increase the potential revenue for private expenditure on care.

Cons

- Take-up – there is no prospect of the multiple demand-side barriers to pre-funded care insurance in England being overcome through public policy interventions.
- Risk-based premiums – the cost of any premiums would rise in line with age and declining, age-related functioning.
- Integration – individuals who purchased pre-funded care insurance several years ahead of claiming may be frustrated if subsequent reforms to integrate health and social care and redefine social care 'needs' and 'costs' were inconsistent with their product. In this sense, the greater use of pre-funded social care insurance is incoherent with future policy choices to integrate the funding, commissioning and delivery of health and social care services.

Pre-funded care insurance and the 'capped cost' care funding reforms

The 'capped cost' care funding reforms, due to be implemented from April 2016, appear wholly unlikely to result in the creation of a pre-funded care insurance market.

First, the reforms are of little consequence to the multiple, entrenched, demand- and supply-side barriers to pre-funded care insurance identified above.

Second, the £72,000 individual 'liability' under the reforms is actuarially uninsurable: insurers will not be able to predict when people's 'care accounts' will start and when they will reach the £72,000 cap. This is because whereas a pre-funded care insurance claim is determined solely on the basis of disability, eligibility for local authority support is determined by disability and multiple uninsurable factors; the availability of informal care, as well as local and national political decisions regarding budgets allocated to social care and the needs eligibility threshold applied.

This could result in anomalous outcomes for consumers, for example, having made a successful claim on a pre-funded care insurance product, they are told that in the view of their local authority, they do not have any eligible care needs owing to the availability of informal care.

There are also broader challenges to creating pre-funded care insurance products aligned with the 'capped cost' reforms. For example, whereas the cap will be uprated annually with inflation, it is prohibitively expensive for insurance products to include inflation guarantees, as demonstrated by the very small number of life annuities sold that are uprated directly in line with inflation.

Pre-funded annuity products

Rather than pre-funded care insurance sold as a standalone product, it could be embedded within an annuity product.

Disability-linked annuities (DLAs), which are not currently available in the UK, would pay a higher income to the person receiving the annuity benefits who was experiencing a defined level of disability. To pay for this higher, disability-linked income, the individual must accept a lower level of pre-disability income.

DLAs confront many of the same demand- and supply-side barriers set out above in relation to pre-funded care insurance, such as ignorance of the risk of needing care, uncertainty around future exposure to care costs, and the need for a new disability-assessment system.

In addition, DLAs confront distinct demand-side barriers that are peculiar to this type of product.

- **Small potential market** – among the 703,000 people turning 65 each year in England, around 30–40 per cent don't have any private pension saving, so would not be able to purchase a DLA. Among those with a private pension, many are in defined benefit schemes, so do not purchase annuities on retirement.

The Institute for Fiscal Studies (IFS) has estimated that among those aged 60–64 in the UK, only 20 per cent have any kind of accumulated, defined contribution pension 'pot', and the median size of such pots is in this age group is £20,000 (Crawford and Tetlow 2012).

If it is assumed that individuals would use up no more than a quarter of their defined contributions pot on protection for care costs for themselves and their partner, and if the 'premium' for a DLA is £10,000, this implies only individuals with more than £80,000 of defined contributions savings would be considered the potential 'target market' for DLAs.

The IFS analysis found that around 20 per cent of all defined contributions pension savers aged 60–64 in the UK have pots of at least £80,000, which would be a potential target market of around 28,000 people each year.

- **Competing motivations among those having an annuity** – what percentage of this target market would be likely to purchase a DLA? Here it is important to note the considerable demand-side barriers to DLAs reflective of the nature of annuity purchases. For example, it is widely observed that many individuals (often men) opt for single-life annuities despite the presence of a non-pensioned partner. This is because a single-life annuity pays out a higher immediate income, but when the individual dies the remaining partner is left with a significant income cut. For the same motivations, people frequently purchase annuities offering no kind of protection against inflation, so the real value of their pension income gradually erodes.

As such, given that many people do not obtain much protection against the substantial risks of both inflation and being survived by their partner, it would not be reasonable to project significant take-up of DLAs in relation to the much lower risk of needing paid care.

Estimating market size

If it is assumed that of a 28,000 potential target market for DLAs each year, take-up is 25 per cent, this would represent around 7,000 products bought each year.

Estimating revenue for the care system

If the average care premium for 7,000 DLAs sold each year was £10,000, which, for the sake of argument is all paid out in claims in one year, minus a 10 per cent profit rate for providers, this would suggest the annual additional revenue available for private expenditure on care would be around £60 million.

However, this figure reflects numerous optimistic assumptions and should be considered at the top end of what might be feasible.

Pros

- If DLAs were introduced in England, this would enable individuals to insure themselves against some of their future potential care costs, and bring some new revenue into the social care system.

Cons

- **Affordability** – only a very small proportion of those with a defined contribution pension have pension pots sufficiently large to be able afford to purchase a DLA.

-
- Equity – take-up would be limited to the highest income households.
 - Integration – individuals who purchased a DLA several years ahead of claiming may be frustrated if subsequent decisions to integrate health and social care, and redefine social care needs and costs, were inconsistent with their DLA.

Disability-linked annuities and the ‘capped cost’ reforms

As with pre-funded care insurance, the ‘capped cost’ care funding reforms appear wholly unlikely to result in the creation of a pre-funded care insurance market.

- The reforms are of little consequence to the multiple, entrenched demand- and supply-side barriers to DLAs.
- Since the £72,000 individual liability under the reforms is actuarially uninsurable, providers of DLAs would not be able to predict when people’s ‘care accounts’ will start and when they will reach the £72,000 ‘cap’, with negative consequence for the experience of consumers.

Point-of-need annuity products

Immediate needs annuities (INAs) are insurance products bought by individuals already experiencing care and support needs, typically upon entering residential care.

In return for a large upfront premium, an INA will pay out a guaranteed income for the rest of someone’s life, whether they live for one year or ten. In this way, INAs protect individuals from longevity risk, ie, the risk that they will live for many years with expensive care needs and subsequently spend many tens of thousands of pounds of their wealth.

A typical INA bought in the current market costs around £80,000 and pays a guaranteed income for life of around £400 per week. There are estimated to be around 7–8,000 INAs in force, and two insurance companies participate in this market.

How large could the INA market grow?

There are currently around 125,000 self-funders in residential care in England. Previous academic analysis has suggested that around 40 per cent, ie, around 50,000 people, have sufficient wealth to make it in their actuarial interest to purchase an INA (Forder 2011).

Current take-up of INAs among those receiving independent financial advice is around 25 per cent according to UK insurer Partnership. If all the potential INA users among self-funders in care homes were to receive independent financial advice, the market could grow from 7–8,000 to 12,500 policies.

Pros

- Protection from care costs – the availability of INAs helps self-funders in residential care protect themselves from catastrophic care costs, albeit in return for a substantial, up-front premium.

-
- Adaptability – as a ‘point of need’ insurance product, the design of INAs can adapt to the configuration of public support for care costs at the time of their purchase. For example, after April 2016 INAs will be able to adapt to the operation of the cap on care costs and higher upper capital limit for residential care. As a point-of-need product, INAs can also adapt to changing entitlements for care costs resulting from future integration of health and social care funding and commissioning.

Cons

- Revenue – aside from the small number of individuals who are prevented from spending and reducing their wealth to the threshold of local authority means-tested support – which it is estimated could potentially save local authorities up to £150 million per year (Forder 2011) – INAs do not actually bring new money into the care system. Instead, they help self-funders in residential care spend their existing capital in a better way by pooling their longevity risk.

Equity release

Equity release products are mortgages taken out by individuals over the age of 55 to release capital from the value of their home to fund their retirement income needs. In particular, equity release enables individuals to access the wealth in their home while continuing to live in it.

Providers charge interest against the value of the mortgage loans, which accrues over time, although the industry has in recent years prioritised ‘no negative equity’ guarantees in the design of products.

According to the Equity Release Council, in 2012 12,500 drawdown and 5,000 lump sum mortgages were sold. The average value of an equity release plan was £52,191.

Pros

- Self-funders of domiciliary and residential care could use equity release products to fund their care costs.

Cons

- Take-up – there is no evidence to suggest that experiencing care and support needs makes individuals more likely to use equity release products. In addition, equity release products confront longstanding demand- and supply-side barriers: consumer aversion to debt, particularly in old age, and negative perceptions of equity release products owing to a legacy of previous mis-selling.
- There is an absence of risk-pooling.
- Revenue – they do not bring new revenue into the social care system, except in so far as any use of equity release products enables individuals to buy more care privately.

Equity release and the universal 'deferred payment scheme'

As part of the package of reforms to the care funding system in England to be introduced alongside the 'capped cost' changes, all local authorities in England are to be subject to a duty to offer 'deferred payment schemes' from 2015.

Under these schemes, self-funders in residential care can opt to have their care fees paid for by their local authority, with the value of this loan repaid at a time of their choosing, for example, when they eventually sell their home or after death. For the first time, local authorities will also be able to charge interest on the loans to make them cost-neutral, at rates that are expected to be below commercial levels.

As such, it would appear that the operation of universal deferred payment schemes in England from 2015 will squeeze out any potential use of private sector equity release products to fund residential care. Any subsequent extension of deferred payment schemes to domiciliary care would also be likely to inhibit their use in this setting.

Care bonds

The idea of care bonds was put forward in 2008, built around the idea of incentivising individuals to save toward future care costs through the operation of a prize draw (Mayhew 2008).

On this approach, care bonds would function in the same way as established NS&I Premium Bonds. A person would buy bonds with a face value of, eg, £1. A small proportion would be deducted and placed in a prize fund that pays out on a regular basis. The bonds would accumulate in value with interest but could only be cashed in when a person becomes disabled or upon death.

Pros

- Acceptability – as a financial product for care, it makes use of a well-known, long-established product: Premium Bonds.

Cons

- Take-up – given potential savers could put their money into conventional Premium Bonds, it is not clear why any individual would opt to put their money into a care bond that can only be accessed upon experiencing a defined level of disability. Individuals who want to save toward their care costs through a Premium Bond-type of product can already do so.
- Role of liquid 'buffer savings' – for lower income and wealth households, it would arguably be irresponsible for the government to encourage them to lock money in savings products that can only be accessed upon experiencing a disability, and cannot be used as 'buffer savings' in relation to any of the other potential adverse income risks that older households confront.

6 State-sponsored insurance schemes

A short overview

A number of countries such as Germany and Japan finance their social care systems through the operation of state sponsored insurance schemes.

This approach can be thought of as sitting between:

- tax-funded financing of care costs
- private insurance for care costs.

State-sponsored insurance schemes display many different characteristics and designs, reflecting the wider health and care systems they operate in, as well as the cultural and political preferences of the country.

For policy-makers, the key attributes of state-sponsored insurance schemes for care are:

- a funded mechanism with capped liabilities for paying for health and social care, unlike general taxation
- the public may be more willing to accept higher 'contributions' if these are directed to a ringfenced scheme demarcated from other areas of public spending and beyond the control of politicians
- the existence of an independent fund changes the institutional framework for public debates on health and social care spending. In particular, when liabilities exceed revenue, the fund, as an independent entity, can be used to explain the need for higher premiums to the public
- the government can specify the rules around both premiums and entitlements, eg, the age at which people contribute, whether contributions are proportional to means, the role of co-payments, gender-neutral premiums, use of auto-enrolment, etc.

In relation to funding social care in England, a state-sponsored insurance scheme would not have to involve increased risk or liabilities for the Exchequer, as the design of a fund could ensure these were held by the private sector – as previous work on a national care fund by the Strategic Society Centre has explored (Lloyd 2011b).

Ultimately the pros and cons of creating a state sponsored insurance scheme for social care in England, the revenue it would bring into the social care system and its interaction with health care and implications for integrated services, would all depend on policy design choices.

References

- Adam S, Browne J, Johnson P (2012). *Pensioners and the tax and benefit system*. London: Institute for Fiscal Studies.
- Age UK (2012). *The cost of cold*. London: Age UK.
- Barrell R, Hurst I, Kirby S (2009). *How to pay for the crisis or macroeconomic implications of pension reform*. London: National Institute of Economic and Social Research.
- Beatty T, Blow L, Crossley T, O’Dea C (2012). *Cash by any other name? Evidence on labeling from the UK Winter Fuel Payment*. London: Institute for Fiscal Studies.
- Browne J, Roantree B (2012). *A survey of the UK tax system*. London: Institute for Fiscal Studies.
- Crawford R, Tetlow G (2012). *Fundholdings in defined contribution pensions*. London: Institute for Fiscal Studies.
- Department of Health (2012). *Caring for our future: progress report on funding*. London: Department of Health.
- Department for Work and Pensions (2012). *Income related benefits: estimates of take-up in 2009–10*. London: Department for Work and Pensions.
- Department for Work and Pensions (2013). *The single-tier pension: a simple foundation for saving*. London: Department for Work and Pensions.
- Forder J (2011). *Immediate needs annuities in England*. London: Personal Social Services Research Unit.
- Hancock R, Morciano M, Pudney S (2010). *Attendance Allowance and Disability Living Allowance claimants in the older population: is there a difference in their economic circumstances?* Essex: Institute for Social and Economic Research Working Paper No. 2010–27, University of Essex.
- Hansard (House of Commons Debates) (2012–13) 11 February 2013, col 593. Available at: www.publications.parliament.uk/pa/cm201213/cmhansrd/cm130211/debtext/130211-0002.htm#13021116000001 (accessed on 20 February 2014).
- HM Revenue & Customs (2011). ‘Inheritance tax estates passing on death in 2008–09’. In: *Inheritance Tax Statistics 2010–11* [online]. Available at: www.hmrc.gov.uk/statistics/inheritance/commentary.pdf (accessed on 20 February 2011).
- HM Revenue & Customs (2010a). *Restricting pensions tax relief through existing allowances* [online]. Available at: www.hmrc.gov.uk/budget-updates/pensions-tax-relief.pdf (accessed on 20 February 2014).
- HM Treasury (2010b). *Restriction of pensions tax relief: a discussion document on the alternative approach*. London: HM Treasury. Available at: www.tisa.uk.com/publications/33_100727pensionstaxreliefrestriction.pdf (accessed on 14 January 2014).
- Humphries R, Forder J, Fernandez J-L (2010). *Securing good care for more people: options for reform*. London: The King’s Fund.

-
- Lloyd J (2013a). *Cold enough: excess winter deaths, winter fuel payments and the UK's problem with the cold*. London: Strategic Society Centre.
- Lloyd J (2013b). *'Independence Allowance': developing a new vision for Attendance Allowance in England*. London: Strategic Society Centre and Independent Age.
- Lloyd J (2012). *The roadmap: England's choices for the care crisis*. London: Strategic Society Centre.
- Lloyd J (2011a). *Charges, taxes, estates and care*. London: Strategic Society Centre.
- Lloyd J (2011b). *Delivering a national care fund: how would a public-private partnership work?* London: Strategic Society Centre.
- Lloyd J (2011c). *Inheritance tax: could it be used to fund long-term care?* London: Strategic Society Centre.
- Lloyd J (2010). *Gone for good? Pre-funded insurance for long-term care*. London: Strategic Society Centre.
- Lloyd J, Ross A (2013). *Attendance Allowance in England*. London: Strategic Society Centre and Independent Age.
- Mayhew L (2008). *The market potential for privately financed long-term care products in the UK*. London: Cass Business School.
- Office for Budget Responsibility (2013). *Fiscal sustainability outlook*. London: Office for Budget Responsibility.
- Office for National Statistics (2012). *Excess winter mortality in England and Wales, 2011/12 (Provisional) and 2010/11 (Final)*. London: Office for National Statistics.
- Wanless D (2006). *Securing good care for older people*. London: The King's Fund.
- Wittenberg R, Hu B, Hancock R, Morciano M, Comas-Herrera A, Malley J, King D (2011). *Projections of demand for and costs of social care for older people in England, 2010 to 2030, under current and alternative funding systems*. Discussion Paper 2811/2. Canterbury: Personal Social Services Research Unit.

About the author

James Lloyd was appointed Director of the Strategic Society Centre in September 2010. He read philosophy at University College London, and has Masters degrees in comparative politics and public policy. James has worked at a number of Westminster thinktanks, and at the Prime Minister's Strategy Unit. He has a particular interest in social care, pensions, housing and financial services, as well as individual and societal ageing. In 2012 he was appointed independent advisor to the opposition on the cross-party talks on social care funding reform. Previous publications include *Asset accumulation in focus: the challenges ahead*, *the roadmap: England's choices for the care crisis* and *Paying for ageing: decision time for households and the state*. His proposal in 2008, for a national care fund is widely acknowledged to have transformed the debate on long-term care funding in England and Wales, and he is a regular commentator on social care reform. James has taken part in various expert working groups and committees for the Department of Health and HM Treasury, and is currently an adviser to the Economic and Social Research Council Research Centre on Micro-Social Change at the University of Essex.

Contact

James Lloyd
Director, Strategic Society Centre
020 7922 7732
james.lloyd@strategicsociety.org.uk
www.strategicsociety.org.uk