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Policy paper

Adult social care charging reform: public sector equalities duty impact assessment

Updated 8 March 2022

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Introduction

The general equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those who do not

The general equality duty does not specify how public authorities should analyse the effect of their existing and new policies and practices on equality, but doing so is an important part of complying with the general equality duty.

The Secretary of State also has a legal duty relating to reducing health inequalities. If you have any questions about that duty, please contact the Health Inequalities team at healthinequalities@dhsc.gov.uk.

Equality impact assessment

Social care charging reform equality impact assessment

This Equalities Impact Assessment reviews the available evidence to consider the equalities impact of Social Care charging reforms, including the introduction of a capped cost model based upon the principles set out by the Dilnot Commission (to be implemented in October 2023). Details of the implementation of this policy have been published in [Build back-better: our plan for health and social care](https://www.gov.uk/government/publications/build-back-better-our-plan-for-health-and-social-care) (<https://www.gov.uk/government/publications/build-back-better-our-plan-for-health-and-social-care>), and include:

- a cap of on the costs to meet their eligible care and support needs for adult residents in England of £86,000
- individuals in residential care will be responsible for daily living costs (DLGs), with means tested support available on the same basis as for care costs. Individuals may also pay top ups for their preferred choice of accommodation. Neither DLGs nor top ups will contribute towards the cap
- after reaching the cap individuals in residential care will remain responsible for a contribution towards DLGs, with means tested support available on the same basis as for care costs
- for each person with eligible needs, the local authority must provide either a personal budget (PB), where the local authority is going to meet the person's needs, or an independent personal budget (IPB), where the person is meeting their own eligible needs. People will progress towards the cap at the rate set out in their PB or IPB, less any local authority financial support they may receive towards their cost should they fall within the means test
- an "extended means test" – with the upper capital limit (UCL) rising to £100,000 and the lower capital limit (LCL) rising to £20,000
- a tariff income (£1 per week for every £250) continues to be applied to those with assets between the lower and upper capital limits
- the minimum income guarantee (MIG) in domiciliary and community care and the personal expenses allowance (PEA) for local authority supported residential care residents will be unfrozen for all adults from April 2022

The aspects of this policy that individuals interact with and are affected by will depend upon their personal care needs as well as their income, assets and wealth. Full details of these interactions are not covered here but will be included in the Social Care Charging Reform Impact Assessment. Instead, the Equalities Impact Assessment considers the whole policy in the context of the Public Sector Equalities Duty. More details of our approach to considering the direct and indirect impacts on different groups are given in the 'Evidence' section below.

Intended outcomes of the policy

The unpredictable nature of care needs means many older people and people with disabilities are facing potentially ruinous bills for their care and support. One in 7 individuals over 65 will face costs above £100,000 and roughly one in 10 will face individuals will face costs above £120,000 over their lifetime. Currently, people face average (mean) care costs of around £45,000.^{[\[footnote 1\]](#)} There is currently no effective way for people to protect themselves from unlimited care costs. This makes it impossible for people to plan and make provision to pay for care with any certainty, and subsequently for them to always access the type of care and support they want. For some, in residential care, this could mean almost the entire value of their home or life savings are eaten up by the cost of care. Protecting against very high care costs so that no one has to sell their home to pay for care is a key priority and manifesto commitment for this government.

The primary objective of the charging reform package is to address the risk individuals face due to unlimited care costs. The reforms should provide people - both older people and working age adults - with financial protection from very high care costs and give them the peace of mind from knowing that they have this protection. Moreover, the policy also aims to increase the protection of those with lower wealth and incomes who fall under the means-test.

There are also secondary objectives, namely:

- to encourage people to take responsibility and to plan and prepare for their care needs in later life
- to support the wider objectives for the care and support system including supporting a sustainable social care market, investment in preventative services and the provision of information and advice to enable people to make effective choices about their care and support

Specific parts of the policy focus on different aspects of current issues with the social care system, producing in combination a holistic policy which seeks to enable an affordable, accessible and sustainable adult social care system that meets people's needs, whilst supporting health and care to join up services around people. The individual elements of the policy are summarised below: more detail will be available in the Social Care Charging Reform Impact Assessment.

A lifetime cap on care costs

In the current system, people lack certainty on future care costs which makes it difficult to plan and prepare. A capped model provides peace of mind and offers a partial risk pool for those whose care costs exceed that of the cap. Not only will the cap itself protect a greater proportion of people's wealth but greater certainty on care costs provides a more stable platform for people to plan for their future, thereby removing uncertain very high costs (that can result in people needing to sell their homes).

Extension of means-tested support

The second component is an extension of the means test by increasing the **LCL** and **UCL**, thereby increasing the number of individuals eligible for state support earlier in their care journey, thus able to protect more of their assets. The extended means test interacts with the protection provided by the cap, so that adults with the least wealth will receive financial support towards their care costs and meter at a slower rate.

Social care allowances

The **MIG** and the **PEA** are an essential part of the charging system and provide individuals with the assurance that they will be left with enough income after social care charges. Allowances have been frozen since 2015 but will be increased for all adults from April 2022.

Full Implementation of Section 18(3) and fair cost of care

All individuals with eligible care needs will have access to the 'local authority rate' of care. To enable this, we will fully enact section 18(3) of the Care Act 2014 which places a duty on the local authority to meet an adult's needs for care and support when requested, even if the adult has assets above the means test threshold, by commissioning care on their behalf.

To support the system transition we're providing additional funding for local authorities to enable them to move towards paying providers a fair and sustainable rate for care. This will support the delivery of sustainable, good quality social care services, enabling providers invest in workforce, innovation and improvement, in line with the Care Act and good practice.

People affected by policy

Social care is currently, and will continue to be, subject to eligibility rules that discriminate positively on the level of care needs.

Whilst the different parts of the charging reform package target different issues within the charging system, the direct beneficiaries of these reforms should reflect the makeup of people receiving care and support (for example, disabled and older people, predominantly women). However, the extent to which individuals will be affected will vary and a wide range of factors – including intensity of care need and level of income, wealth and assets – will influence who receives direct and indirect benefits from the policy.

Care users

The direct beneficiaries of the policy will be those who require formal support for their care needs. The policy will help these individuals plan for and manage the costs of their care, and will offer increased protection for people's income, assets and wealth. It will also provide greater peace of mind in relation to people's future ability to access care and would mean that individuals are more able to access care that is appropriate for their eligible needs. These benefits will apply to both those who currently have care needs, and those who may require care in the future. While the policy provides specific protection for people with a range of care needs and income, assets and wealth, we would expect the policy to have particular benefits for:

- those with more intense or longer lasting care needs
- those who are less able to plan for the future because their care needs are complex or unpredictable
- those whose income, assets and wealth mean that they have more uncertainty over how they will meet the cost of care for these needs in the future

Unpaid carers

We would also expect this policy to benefit unpaid carers by offering them greater peace of mind about the potential future care and care costs of the person they care for.

The general (non-care user) population

This policy will have benefits for the general population in that it will provide peace of mind and increased certainty over future ability to meet the costs of care from all those who could potentially have care needs in the future, regardless of whether they actually go on to develop these needs.

Evidence

Overall approach

In line with the public sector equality duty, this equalities impact assessment considers whether the proposed package of social care reforms will:

- eliminate unlawful discrimination
 - this policy does not directly differentiate based on protected characteristics (with the exception of specific charging rules to ensure equity between those who are married or in a civil partnership and those who are not, which will be discussed below). It will not therefore lead to unlawful discrimination against those with protected characteristics
- foster or encourage good relations between people who share a protected characteristic and those who do not
 - this is not a specific aim of the policy and there is no evidence – either from research or from stakeholder engagement – to suggest that the policy will have any impact on relations between people who share a protected characteristic and those who do not. However, monitoring and evaluation of the policy will consider unintended consequences and will further assess whether there are any equalities impacts in this respect.

- advance equality of opportunity between people who share a protected characteristic and those who do not
 - there may be areas in which the policy advances equality of opportunity between people who share a protected characteristic and those who do not, as some people who share protected characteristics might be more likely than those who do not to have specific needs in relation to the care system

Based on the aims of the policy (outlined above), we expect the following factors to affect if and how individuals benefit from the proposed reforms.

Uptake of formal care

Groups who are more likely to access formal care are more likely to benefit from this policy.

Likelihood of developing care needs

Groups who are more likely to develop care needs will be more likely to benefit from this policy.

Average intensity of care needs (and therefore cost of care)

Groups with more intensive care needs and higher lifetime care costs are more likely to benefit from this policy.

Certainty over future care needs and ability to meet them

This policy provides specific protection for people with different levels of income, assets and wealth – full details will be available in the social care charging reform impact assessment. However, we expect there to be particular benefits for those who have less certainty about how they will meet the cost of any future care needs, either because they have lower or less certain income, assets and wealth or because they have more unpredictable care needs.

Likelihood of being an unpaid carer

This policy will benefit groups who are more likely to provide informal care. It will offer greater peace of mind about how the care recipient will meet their future care needs and access formal support in the future.

Need for specialised services

Groups who require specialised care services may receive some benefits from the impact of this policy on the wider social care market.

This document therefore considers the evidence against each of these factors for each protected characteristic in order to determine whether individuals who share any single protected characteristic are more or less likely than others to benefit from the policy. We have conducted a purposive review of available data and literature according to this framework.

While this was not a systematic review of available literature, we have considered relevant national-level datasets and official statistics as well as existing summary and systematic reviews to inform this Equalities Impact Assessment. The key overarching data sources we have considered include:

- [Adult Social Care Activity and Finance Report, England – 2019 to 2020](https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20) (<https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20>)
- [Personal Social Services Adult Social Care Survey, England 2019 to 2020](https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-adult-social-care-survey/england-2019-20) (<https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-adult-social-care-survey/england-2019-20>)
- [Family Resources Survey: financial year 2019 to 2020](https://www.gov.uk/government/statistics/family-resources-survey-financial-year-2019-to-2020/family-resources-survey-financial-year-2019-to-2020) (<https://www.gov.uk/government/statistics/family-resources-survey-financial-year-2019-to-2020/family-resources-survey-financial-year-2019-to-2020>)
- [Social care 360: access \(2020\)](https://www.kingsfund.org.uk/publications/social-care-360/access) (<https://www.kingsfund.org.uk/publications/social-care-360/access>)
- [The Report of the Commission of Funding of Care and Support: Fairer Care Funding, July 2011](https://webarchive.nationalarchives.gov.uk/ukgwa/20130221121534/fhttp://www.dilnotcommission.dh.gov.uk/our-report/) (<https://webarchive.nationalarchives.gov.uk/ukgwa/20130221121534/fhttp://www.dilnotcommission.dh.gov.uk/our-report/>)

Where these have highlighted issues, we have gone further in exploring additional evidence for specific protected characteristics. These are summarised in the table below. Full referencing is included throughout this document.

Protected characteristic	Key sources
Disability	Outcomes for disabled people in the UK, 2020 - Office for National Statistics (dataset A08: Labour market status of disabled people) (https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/labourmarketstatusofdisabledpeopleanddisabilitypaygapsintheuk2018) Disability pay gaps in the UK, 2018 (Section 6) - Office for National Statistics (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/articles/disabilitypaygapsintheuk/2018#disabled-employees-and-disability-price-tag) Disability Price Tag (2019) - Disability charity Scope UK (https://www.scope.org.uk/campaigns/extra-costs/disability-price-tag/)
Sex	Gender pay gap in the UK - Office for National Statistics (https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandwork) Labour market overview, UK - Office for National Statistics (https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandlabourmarket) Pension wealth in Great Britain - Office for National Statistics (https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/incomeandwealth/bulletins/pensionwealthingreatbritain/april2019)
Sexual orientation	Sexual orientation, UK - Office for National Statistics (https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins) Kneale et al (2019) Inequalities in older LGBT people's health and care needs in the United Kingdom: a systematic scoping review (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/inequalitiesanddisparities/bulletins/inequalitiesinolderlgbtpeopleshealthandcareneeds) Booth et al (2020) Diversity and inequalities of access in social care - Social Care Access for BAME/LGBT populations (https://www.fun.gov.uk/publications/social-care-access-for-bame-lgbt-populations)

Protected characteristic	Key sources
Race	Public Health England, Public health outcomes framework, 2016 to 2017 (https://www.ethnicity-facts-figures.service.gov.uk/health/physical-health/latest/average-health-related-quality-of-life-score-for-people-aged-65-and-older) Public Health England, Local action on health inequalities, 2018 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730917/local_action_on_health_inequalities.pdf) Employment - GOV.UK Ethnicity facts and figures (https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/employment/employment) Household income - GOV.UK Ethnicity facts and figures (https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/pay-and-income)
Age	The Health Foundation, April 2020: Social Care for Adults aged 18 to 64 (https://www.health.org.uk/sites/default/files/upload/publications/2020/64_Analysis.pdf)
Gender reassignment	Kneale et al (2019) Inequalities in older LGBT people's health and care needs in the United Kingdom: a systematic scoping review (https://core.content/view/FDF7D2BC9C59B50FFF13B5A796D48259/S0144686X19001326a.pdf/inequalities_in_older_lgbt_peoples_health_and_care_needs) Government Equalities Office, National LGBT Survey research report (2018) (https://www.gov.uk/government/publications/national-lgbt-survey-research-report-2018) House of Commons Women and Equalities Committee: Health and Social Care and LGBT Communities (2019) (https://publications.parliament.uk/handl/yh?URN=55702/PN2019-0001)
Religion or belief	In the absence of specific relevant evidence, this section relies on the overarching data sources listed above
Pregnancy or maternity	In the absence of specific relevant evidence, this section relies on the overarching data sources listed above
Marriage or civil partnership	Pickard (2008), Sources of Informal Care: Comparison of ELSA and GHS, PSSRU Discussion Paper no. 2598 (https://www.pssru.ac.uk/TotalWealth/Wealth%20in%20Great%20Britain%202019) Total Wealth: Wealth in Great Britain, 2019 - Office for National Statistics (https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/incomeandwealth/datasets/totalwealthwealthingreatbritain)

Evidence gaps

Our assessment of the evidence has highlighted some potential gaps within the evidence on the social care user population. These include granular detail on the characteristics of care users, and in particular on how the following protected characteristics interact with uptake of formal care:

- sexual orientation
- gender reassignment
- religion or belief
- pregnancy or maternity

As this policy does not treat people differently on the basis of any of these characteristics, and because of the wider research we have reviewed, we do not believe that a lack of granular data on care needs and usage among these groups is a barrier to making an appropriate assessment of the equalities impact of this policy. However, the Department of Health and Social Care (DHSC) is continuing to conduct and support research and analysis on the characteristics of the care users and emerging evidence in this area will be considered in any future policy development. Additionally, the monitoring and evaluation of this policy will consider unintended consequences of the policy and will further assess whether there are any equalities impacts in this respect.

Analysis of impacts

Impacts for each of the 3 aims of the Public Sector Equality Duty – eliminating unlawful (direct and indirect) discrimination, advancing equality of opportunity, and fostering good relations.

Disability – attitudinal, physical and social barriers for both visible and hidden disability

Many people with care needs will have a disability, defined as a long-term physical or mental health condition or illness which limits ability to carry out day-to-day activities.^[footnote 2] The NHS Digital Activity and Finance Report for 2019 to 2020 (<https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20>) shows that 54% of local authority clients accessing long-term support at the end of the year were receiving care for physical support needs, while 23% received support related to learning disabilities and 11% for mental health support needs. While these support needs are not exact proxies for disability, they are a good indicator of need for social care.^[footnote 3] By supporting those with hidden and visible disabilities in meeting the costs of their care, we expect this policy to benefit people with disabilities and to advance equality of opportunity between those with disabilities and those without.

The intensity – and therefore cost – of care for individuals with a disability is likely to be more severe than for care users who are not disabled. This population will therefore be at particular risk of high lifetime care costs and providing greater certainty over these will be beneficial for this group. This is particularly true for those whose needs fluctuate or are unpredictable, as this could lead to a higher level of uncertainty and anxiety about the future cost of care.

This is exacerbated by the fact that those with disabilities may have lower incomes and assets and less ability to earn than the general population, meaning that they have less certainty over their ability to manage the future cost of their care. Data from the [Labour Force Survey 2020 \(https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/articles/outcomesfordisabledpeopleintheuk/2020#employment\)](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/articles/outcomesfordisabledpeopleintheuk/2020#employment) show that 48% of disabled people aged 16 to 64 years were unemployed compared to 19% in the non-disabled population. People with disabilities also typically face higher costs of daily living than those without disabilities as a direct result of their disability^[footnote 4]. Supporting these groups to meet their care needs will advance equality of opportunity between disabled and non-disabled people.

People with disabilities could also benefit from wider impacts on the social care market as a result of these reforms. We expect the combination of a cap on lifetime care costs, the full implementation of s18(3) and local authorities paying a fair rate for care to have benefits for the wider social care market, including encouraging investment and innovation. Increased innovation – and in particular, a greater range of available care services – could be particularly beneficial for disabled people, who may have complex or unique care needs and therefore require specialised support.

It should be noted that any benefits stemming from greater ‘peace of mind’ as a result of a cap on lifetime care costs rely on the clear communication of the policy and what it means for individuals. Consideration will need to be given to how this can be done in an inclusive and accessible format to ensure that those with learning disabilities, cognitive impairment or other additional needs are fully informed.

Sex: men and women

This policy does not treat people differently based on their sex or gender. However, there are various factors which may mean that women are more likely to benefit from the support this policy offers and that this policy will thereby promote equality of opportunity between these 2 groups.

Women in England are more likely than men to receive formal care: over half (58%) of the publicly funded or managed care population in England is female.^[footnote 5] Women are therefore likely to receive particular benefits from this policy.

In addition, women are more likely than men to be disabled. In the [2019 to 2020 Family Resources Survey](https://www.gov.uk/government/statistics/family-resources-survey-financial-year-2019-to-2020) (<https://www.gov.uk/government/statistics/family-resources-survey-financial-year-2019-to-2020>), 24% of females reported having a disability compared to 19% of males. Across all age groups except those below aged 15, a higher proportion of females than males reported that they were disabled. Please see above for an assessment of how this policy will benefit disabled people compared to those without disabilities.

There are also differences in income, wealth and assets between men and women which could affect how they benefit from this policy. Estimates from the [Office for National Statistics](https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/humancapitalestimates/2004to2018#human-capital-by-sex) (<https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/humancapitalestimates/2004to2018#human-capital-by-sex>) (ONS) indicate that women’s lifetime earnings are substantially lower than men’s: in 2018 women received, on average, equal to 59% of men’s lifetime earnings. This means that they are likely to have less certainty over how they will meet the costs of their future care needs and will be particularly likely to benefit from this policy. Further details of how this policy will interact with individual levels of income, assets and wealth will be available in the social care funding reform impact assessment.

Women may also be more likely to receive the benefits of this policy because they are more likely to provide informal care than men. In 2019 to 2020, 2.7 million women provide informal care versus 1.8 million males, according to data from the [Family Resources Survey](https://www.gov.uk/government/statistics/family-resources-survey-financial-year-2019-to-2020) (<https://www.gov.uk/government/statistics/family-resources-survey-financial-year-2019-to-2020>). The benefits of the reforms for unpaid carers, which include greater peace of mind over the care recipient’s future support, will therefore be likely to have a disproportionately positive impact on women.

Sexual orientation: heterosexual, homosexual, bisexual or other sexual orientations

This policy does not treat people differently based on their sexual orientation, and we have no reason to believe that people of any one sexual orientation are more likely to receive direct benefits from it than any other. There may be some marginal benefits which are particularly important for lesbian, gay, bisexual individuals or others who are not heterosexual. The acronym ‘LGBQ’ (lesbian, gay, bisexual or queer) is used in this section to refer to these groups. The impact on transgender individuals or groups is considered separately in relation to the protected characteristic ‘gender reassignment’. Where individual evidence sources or papers use a different acronym or terminology, the term used by the original source is kept to ensure that the evidence is represented accurately (for example, ‘LGBT’ or ‘LGBTQ’ are frequently used when research considers the LGBQ and transgender populations as a whole).

We do not have robust data on the proportion of the care population in England that is LGBQ, or on how this compares to the general population. Data from the 2019 to 2020 Adult Social Care Survey indicates that care users are less likely than the general population (take from ONS experimental statistics on sexual orientation in the UK in 2018) to specifically identify as heterosexual / straight. However, a higher proportion of respondents to this survey answered ‘don’t know’ or refused this question than in the general population estimates. The amount of people specifically identifying as bisexual was lower in the Adult Social Care Survey than in the ONS estimates for the general population. These differences have not been tested for statistical significance.

Sexual orientation	% of care population (publicly funded or managed clients only)	% of whole population in the UK
Heterosexual or straight	63%	95%
Gay or lesbian	1%	1%
Bisexual	0.3%	1%
Other	1%	1%
Don’t know or refused	35%	3%

Sources: Personal Social Services Adult Social Care Survey, NHS Digital (2019 to 2020), [ONS \(2018\)](https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2018) (<https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2018>)

Consultation conducted as part of the Dilnot commission in 2011 indicated that the increased certainty and peace of mind offered by a cap on lifetime care costs may be particularly important for LGBQ people. This work suggested that some are concerned about how they will manage future care and support needs as they may be less likely to have access to unpaid care from family members.^[footnote 6] These concerns are supported by research which suggests that the social networks of older lesbian and gay people were structured differently compared to those of non-LGBT people which may increase the risk of requiring formal as opposed to informal care.^[footnote 7]

We expect the combination of a cap on lifetime care costs, the full implementation of s18(3) and local authorities paying a fair rate for care to have benefits for the wider social care market, including encouraging investment and innovation. This may be particularly important for LGBQ groups: the [Women and Equalities Committee report on Health and Social Care and LGBT Communities \(2019\)](#)

(<https://publications.parliament.uk/pa/cm201919/cmselect/cmwomeq/94/94.pdf>) suggested that LGBT care users might have specific needs and that services will be ineffective if “[they are] structured for a heterosexual and cisgender default and has limited flexibility”. The report found that for many users, sexual orientation is a crucial consideration when providing personalised care: LGBQ care users could therefore benefit from a more innovative care market with a greater range of services offering increased flexibility and / or care packages specifically targeting their needs.

Race: ethnic groups, nationalities, Gypsy, Roma, Travellers, language barriers

This policy does not treat people differently based on their race. However, some groups may receive particular benefit from the reforms if they are more likely than others to have care needs or to access formal care.

While there is evidence suggesting that people from minority ethnic groups face personal, community and structural barriers which limit their access to social care^[footnote 8], we do not currently have robust data to indicate whether there is any difference in care needs or uptake of formal care between different ethnic groups. The Adult Social Care Survey and ONS population estimates indicate that there are only minor differences between the care user population and the general population in terms of ethnicity. On this basis, we would not expect any ethnic group to be more likely to directly benefit from this policy. However, these differences have not been assessed for statistical significance and further research and / or data may be needed in this area.

Ethnicity	Care population (publicly funded or managed clients only) (%)	% of whole population in England
White	85%	85%
Mixed and Multiple Ethnic groups	1%	2%
Asian or Asian British	5%	8%
Black, African, Caribbean and Black British	4%	3%
Other	1%	1%
Unknown or not given	4%	N/A

Sources: [Personal Social Services Adult Social Care Survey, NHS Digital 2019-20](https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-adult-social-care-survey/england-2019-20) (<https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-adult-social-care-survey/england-2019-20>), [Official Labour Market Statistics, ONS 2011](https://www.nomisweb.co.uk/census/2011/ks201uk) (<https://www.nomisweb.co.uk/census/2011/ks201uk>)

There is some evidence that some ethnic groups may be more likely than others to have care needs. For example, disability-free life expectancy is lowest for Pakistani and Bangladeshi groups^[footnote 9] and health-related quality of life score for older adults are lower amongst many ethnic minority groups relative to the White British group, according to the 2017 GP patient survey^[footnote 10]. By supporting those with care needs to access appropriate and affordable care, this policy may have particular benefits for some ethnic groups and thereby encourage equality of opportunity for those who share a protected characteristic and those who do not.

There are also differences in income, wealth and assets between different ethnic groups which mean that these groups may be more likely to benefit from different aspects of this policy. For example, some ethnic minority groups are overrepresented amongst groups of lower socioeconomic status: this could mean that they have less certainty over their ability to manage any future care needs. Employment is lower for all ethnic minority groups relative to white groups^[footnote 11], while households in Black (34%) and Chinese (31%) ethnic groups are the most likely to have a weekly income of less than £400, compared to 28% of all households^[footnote 12]. Where ethnicity is associated with greater uncertainty over ability to meet the future costs of care we would expect this policy to have particular benefits for the groups in question. Further details of how this policy will interact with individual levels of income, assets and wealth will be available in the social care funding reform impact assessment.

It should be noted that any benefits stemming from greater ‘peace of mind’ as a result of a cap on lifetime care costs rely on the clear communication of the policy and what it means for individuals. Consideration will need to be given to how this can be done in an inclusive and accessible format to ensure that those who speak English as an additional language are fully informed.

Age: age ranges, old and young

This policy applies to adults aged 18 and over: children who have care needs will be supported through Children’s Services, either through the Children’s Social Care System or through the Special Educational Needs and Disabilities System.

Amongst the adult population, the policy does not discriminate or differentiate based on age. However, existing social care charging rules set the rates of the Minimum Income Guarantee based on a range of factors, including age, disability and couple status meaning that younger adults receive a different allowance to those who are of pension credit age.

The proposed reforms will see an uplift across social care allowance rates in April 2022 for all individuals but will not adjust the differences between the allowances received by different groups.

Some age groups will be more likely than others to benefit from these reforms, based on their social care needs. For example, older adults (65+) are more likely than younger adults (18 to 64) to have care needs and to access formal care: they will therefore see particular benefits from this policy. [NHS Digital data from 2019 to 2020](https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20) (<https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20>) shows that 60% of publicly funded or managed recipients of long-term social care users are over 65.

There may also be other factors which affect how likely different groups are to benefit from these reforms. For example, young people who have care needs may have greater uncertainty over both their future care costs and their ability to manage these than older adults. For further exploration of how these factors may impact younger people, please see the above assessment of how this policy may impact people with disabilities. Further exploration of how the policy will interact with specific levels of income, wealth and assets, and of how the policy will impact care users aged 18 to 64 and 65+, will be available in the social care funding reform impact assessment.

The benefits of this policy for informal carers will have a greater positive effect on adults over 55 years. Data from the [Family Resources survey 2019 to 2020](https://www.gov.uk/government/statistics/family-resources-survey-financial-year-2019-to-2020/family-resources-survey-financial-year-2019-to-2020) (<https://www.gov.uk/government/statistics/family-resources-survey-financial-year-2019-to-2020/family-resources-survey-financial-year-2019-to-2020>) shows that those aged between 55 and 64 were the largest single group of informal care providers.

In providing benefits in line with the specific needs of individuals in different groups, this policy will advance equality of opportunity between those who share a protected characteristic and those who do not.

Gender reassignment: transgender and transsexual people

This policy does not treat people based differently on their gender or gender reassignment status. However, other factors may impact how likely transgender or transsexual people are to benefit from this policy.

There is no data currently available on the proportion of the care population in England that identifies as transgender, or on how this compares to the general population. However, there is some evidence that transgender people might face particular barriers to taking up formal care. For example, a 2019 scoping review concluded that social care environments appeared as a focal point for inequities and that formal care environments could seriously compromise the identity and relationships that older LGBT people developed over their life course. These factors, whether actual or perceived, may prevent some transgender individuals accessing formal care.^[footnote 13] There is little evidence specifically on access to care for transgender individuals: however, we would expect many of the issues reported for the LGBT population as a whole to be exacerbated for this population. For example, the Government Equalities Office National LGBT Survey (2018) found that 40% of transgender respondents had had a negative experience with healthcare in the 12 months preceding the survey, compared to 13% of cisgender respondents.

In providing benefits in line with the specific needs of individuals in different groups, this policy will advance equality of opportunity between those who share a protected characteristic and those who do not.^[footnote 14]

These reforms will not address these issues directly: indeed, if transgender individuals are not accessing social care for the reasons outlined above, they may be less likely than the general population to benefit even where they are eligible.

Conversely, the policy may remove barriers to accessing care for transgender people by giving greater certainty over their future care costs. Consultation conducted as part of the Dilnot commission in 2011 indicated that this may be particularly important for transgender people, who may be more likely to be concerned about how they will manage future care and support needs due to reduced access to unpaid care from family members.^[footnote 15] These concerns are supported by research which suggests that the social networks of older lesbian and gay people were structured differently compared to those of non-LGBT people which may increase the risk of requiring formal, as opposed to informal, care.^[footnote 16] While this research does not differentiate between cisgender and transgender people specifically, we would expect these issues to be similar or exacerbated for transgender people.

Additionally, the available evidence indicates that transgender individuals are likely to have lower or less stable incomes than the wider population. For example, the [Government Equalities Office National LGBT Survey \(2018\)](https://www.gov.uk/government/publications/national-lgbt-survey-summary-report) (<https://www.gov.uk/government/publications/national-lgbt-survey-summary-report>) found that trans respondents were more likely to earn less than £20,000 per annum (60%) than cisgender respondents (45%) and were much more likely to say that they did not know their personal income (10%) than cisgender respondents. Where this leads to greater uncertainty over individual's ability to meet future care costs, the policy will promote equality of opportunity between those who share a protected characteristic and those who do not.

We expect the combination of a cap on lifetime care costs, the implementation of s18(3) and local authorities paying a fair and sustainable rate for care to have benefits for the wider social care market, including encouraging investment and innovation. This may be particularly important for LGBQ groups: the [Women and Equalities Committee report on Health and Social Care and LGBT Communities \(2019\)](https://publications.parliament.uk/pa/cm201919/cmselect/cmwomeq/94/94.pdf) (<https://publications.parliament.uk/pa/cm201919/cmselect/cmwomeq/94/94.pdf>) suggested that LGBT care users might have specific needs and that services will be ineffective if "[they are] structured for a heterosexual and cisgender default and has limited flexibility". The report found that for many users, sexual orientation is a crucial consideration when providing personalised care: we would expect this to also apply to gender reassignment, and transgender care users could therefore benefit from a more innovative care market with a greater range of services offering increased flexibility and / or care packages specifically targeting their needs.

Religion or belief: people with different religions, beliefs or no belief

This policy does not treat people differently based on religion or belief. However, other factors may influence how the policy could impact people of a specific religion or belief.

We do not have robust data on whether there is differential access to or take-up of formal care between religious groups. Comparisons between the adult social care survey and 2011 census data suggest that there may be some differences. However, it is not clear to what extent these are explained by differences in the number of people who refused to answer this question across the two surveys. These differences have not been assessed for statistical significance.

Religion	Care population (publicly funded or managed clients only) (%)	% of whole population in England
None	14%	25%
Christian	65%	59%
Buddhist	0%	0.5%
Hindu	1%	2%
Jewish	1%	0.5%
Muslim	5%	5%
Sikh	1%	1%
Other	6%	0.4%

Religion	Care population (publicly funded or managed clients only) (%)	% of whole population in England
Refused to say or not stated	8%	25%

Sources: [Personal Social Services Adult Social Care Survey, NHS Digital \(2019 to 2020\)](https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-adult-social-care-survey/england-2019-20) (<https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-adult-social-care-survey/england-2019-20>), [Official Labour Market Statistics, ONS 2011](https://www.nomisweb.co.uk/census/2011/KS209EW/view/2092957699?cols=measures) (<https://www.nomisweb.co.uk/census/2011/KS209EW/view/2092957699?cols=measures>)

We know that some people with different religions or beliefs may have different social care needs. For example, some people may face language or cultural barriers to accessing services, while other people may have special dietary requirements or needs to mark religious days in particular ways.^[footnote 17] We expect the combination of a cap on lifetime care costs, the full implementation of s18(3) and local authorities paying a fair and sustainable rate for care to have benefits for the wider social care market, including encouraging investment and innovation: this may lead to a greater range and flexibility of services available which can better meet individual or specific care needs for certain religious groups.

With greater certainty over future care costs, individuals will have greater choice and control over how they plan for the future. It may be that some groups prefer to or need to meet their contributions up to the cap in certain ways in line with their beliefs, and they would have the flexibility to do so under this policy.

Pregnancy or maternity: working arrangements, part time working, infant caring responsibilities

This protected characteristic refers to individuals who are pregnant, breastfeeding or have recently given birth. We do not have robust data on the proportion of care users who meet this description.

Where individuals do share a protected characteristic related to pregnancy or maternity, they will benefit in the same ways as other care users who do not share the protected characteristic.

Those who share this protected characteristic may be more likely than the general population to face uncertainty over their future income or ability to meet the cost of care if their working arrangements are affected by pregnancy or infant caring responsibilities. If this is the case, this group may receive additional benefits from the increased peace of mind offered by this policy.

We expect the combination of a cap on lifetime care costs, the implementation of s18(3) and local authorities paying a fair and sustainable rate for care to have benefits for the wider social care market, including encouraging investment and innovation. While we do not currently have evidence of specific care requirements related to pregnancy or maternity, it may be that individuals sharing this protected characteristic could benefit from a more innovative care market with a greater range of services offering increased flexibility and / or care packages specifically targeting their needs.

Marriage or civil partnership: married couples, civil partnerships

Current social care charging policy treats married people and single people differently in order to promote equality between these groups and ensure that those who are married are not at greater risk of having to sell their home than single people because of their married status. There are also some situations in which those who are married or in a civil partnership might be more likely to benefit from social care charging rules which mean that their home isn't taken into account in the means test. This applies when the care user's home is still occupied by:

- a partner or former partner, unless they are estranged
- an estranged or divorced partner IF they are also a lone parent
- a relative who is aged 60 or over
- a relative who is disabled
- the individual's child who is aged 18 or under

The proposed reform policy will maintain this protection: neither married people nor single people will stand to benefit or be disadvantaged compared to each other relative to the current policy. The policy does not differentiate between people who are married and people who are in a civil partnership.

Single people are more likely than married people to access formal care. In the [2011 census](https://www.nomisweb.co.uk/census/2011/dc1116ewla) (<https://www.nomisweb.co.uk/census/2011/dc1116ewla>), 85% of the aged 65+ population receiving residential care were non-married: this group includes those who have never been married as well as those who are divorced, separated or widowed. Single people may therefore receive particular benefits from this policy.

However, there are a range of benefits to this policy which may impact on different groups in different ways. For example, individuals who live with a partner or who have children are more likely to receive informal care in their older age.^[footnote 18] This group may be more likely to receive the benefits of this policy to informal carers, including greater peace of mind over the care recipient's future support. However, single people may face greater uncertainty over their future care due to reduced access to informal care: in this context, the policy will have particular benefits for these individuals by giving them greater peace of mind over how they will meet their future care needs.

In providing benefits in line with the specific needs of individuals in different groups, this policy will advance equality of opportunity between those who share a protected characteristic and those who do not.

Engagement and involvement

Engagement with stakeholders in gathering evidence

We carried out 10 in depth interviews with people with lived experience of the care sector, as well as 8 focus groups with the general public. Five interviews were with those who receive domiciliary care one or 2 times a week, and 5 interviews were with those who receive domiciliary care at least 4 times a week. The focus groups were:

- group 1: age 25 to 35. ABC1; recruited across England
- group 2: age 25 to 35. C2DE; recruited across England

- group 3: age 40 to 55. ABC1; recruited across England
- group 4: age 40 to 55. C2DE; recruited across England
- group 5: age 60 plus. ABC1; recruited across England
- group 6: age 60 plus. C2DE; recruited across England
- group 7: age 60 plus. C2DE; all living in the north of England
- group 8: age 40 to 55. C2DE; all living in the north of England

There was a low level of understanding of the social care system and of funding arrangements in particular, however once shown details of the current system, most people across all demographics felt that a lack of a cap for care costs was unfair for both those receiving care and their family members. Many people also felt that the current funding arrangements promoted the potential for “gaming” the system by transferring assets. Additionally, there was consensus that the current means test threshold of both £14,250 and £23,250 were too low and did not reflect contemporary wealth norms.

Proposed changes, including a more generous means test (raising the floor to £100,000) and a cap of costs were seen as a distinct improvement on the current system across all demographics, in particular, the addition of a cap was reassuring to most people, and was seen as more likely to prevent the need to sell one's home to pay for care.

Engagement with stakeholders in shaping the policy proposals

We engaged with over two dozen stakeholders from the adult social care sector individually and in roundtables throughout Summer and Autumn 2020, to explore the objectives, choices and deliverability of options for reforming how care is paid for alongside wider reform of the social care system.

We asked stakeholders to detail their core objectives when considering how care is paid for, which government funding model they thought could best achieve these, and their views on the Dilnot charging model versus insurance-based funding models.

Organisations involved in the discussions included:

- Age UK
- Association of Directors for Adult Social Services
- Associated Retirement Community Operators
- British Association of Social Workers
- Care Association Alliance
- Care England
- Care Providers Alliance
- Care Quality Commission
- Care UK
- Carers UK
- GMB Union
- HC One
- Health Foundation
- King's Fund
- Learning Disability England
- Local Government Association
- Mencap
- National Association of Care and Support Workers
- National Care Forum
- National Development Team for Inclusion
- Nuffield Trust
- Registered Nursing Home Association
- Royal College of Nursing
- Royal College of Occupational Therapists
- Sense, Shared Lives Plus
- Skills for Care
- Social Care Institute for Excellence
- Solace
- UK Homecare Association
- Unison

There was wide support for a model which included risk pooling and the capping of very high, such as Dilnot. In contrast, stakeholders were clear that a voluntary insurance model would be unlikely to succeed and highlighted the lack of an insurance culture within the UK.

Summary of analysis

This policy does not directly differentiate based on protected characteristics. We do not therefore believe it will lead to unlawful discrimination between those with protected characteristics, and has a neutral impact on elimination of discrimination, harassment and victimisation.

We have no reason to believe that the policy will have any impact on relations between people who share a protected characteristic and those who do not: the impact here is neutral.

There may be areas in which the policy advances equality of opportunity between people who share a protected characteristic and those who do not, as some people who share protected characteristics might be more likely than those who do not to have specific needs which mean that they will benefit from this policy.

The below table summarises specific potential impact in relation to different groups who share a protected characteristic. Where an impact is assessed as 'neutral', we have no reason to believe that there is an impact in either direction, relative to the current social care charging system. Where an impact is listed as 'neutral*', there is some indicative evidence of a potential positive impact, but this is not robust or conclusive enough to be definitive.

Overall impact

	Elimination of discrimination, harassment and victimisation	Relations between groups who share a protected characteristic and those who do not	Equality of opportunity between groups who share a protected characteristic and those who do not
Disability	Neutral	Neutral	Positive
Sex	Neutral	Neutral	Positive
Sexual orientation	Neutral	Neutral	Neutral*
Race	Neutral	Neutral	Neutral*
Age	Neutral	Neutral	Positive
Gender reassignment	Neutral	Neutral	Neutral*
Religion or belief	Neutral	Neutral	Neutral
Pregnancy or maternity	Neutral	Neutral	Neutral
Marriage or civil partnership	Neutral	Neutral	Neutral

Addressing the impact on equalities

As above, we expect this policy to have neutral or positive impacts in relation to the Public Sector Equalities Duty. Where evidence is less conclusive or is insufficient to be confident in these impacts, we recommend further monitoring and evaluation of the impacts of the policy on specific groups as part of the overall evaluation plan set out below.

We have identified that one potential risk to ensuring that those who share a protected characteristic have equal access to the benefits of the policy is the need for clear communication that meets specific accessibility needs. DHSC will ensure that guidance and information in relation to the policy considers these needs, including:

- the need to ensure that materials are accessible to those who do not speak English as their primary language
- the need to ensure that materials are accessible to those with a range of disabilities or other additional needs

Monitoring and evaluation

Funding reform will be reviewed and monitored and will be subject to robust process and impact evaluation. This will include monitoring and evaluation of impacts on users and carers with protected characteristics in line with the Public Sector Equality Duty.

Data to monitor the reforms will be collected, including the number of people benefiting from the extended means test and the number who reach the cap.

The Care Act 2014 legislated for a 5-yearly review by the Secretary of State, which must review the level of the cap, daily living costs and means test threshold. It must have regard to the impact on adults who share a protected characteristic in line with the Public Sector Equality Duty.

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