



# Rebooting the Cap

Improving protection from catastrophic care costs



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# Executive Summary

In July 2015, the Department of Health announced that the ‘capped cost’ reforms to care funding in England would be postponed until April 2020, given a difficult outlook for public spending and the absence of evidence of a complementary social care insurance market emerging.

Following this announcement, social care campaigners have questioned whether the ‘capped cost’ reforms will be postponed again before 2020, or scrapped completely. However, another scenario exists: implementation of an alternative reform package during the current parliament based on the principle of capping people’s care costs. Such an approach would:

- ▶ Allow the government to meet its political commitment to cap people’s care costs;
- ▶ Enable a refreshed set of reforms to care funding in England that take account of recent developments in health and social care policy, and avoid downsides to the ‘capped cost’ reforms such as complexity and potential unintended consequences;
- ▶ Address the unfairness and uncertainty that characterizes England’s care funding system.

The principle underpinning the ‘capped cost’ reforms reflects the fact that insurers struggle to offer simple pre-funded insurance in relation to long-term care that protects people against catastrophic care costs. This results in an important moral and practical consequence for policymakers: if individuals are to be protected from incurring catastrophic social care costs, only the state can offer this protection.

Building on this principle, the ‘capped cost’ model has three core elements:

- ▶ A cap of £72,000 on the assessed, eligible lifetime care costs that adults are expected to meet
- ▶ An increase in the upper capital threshold for residential care from £23,250 to £118,000 for people living in a care home whose property has not been disregarded from the means test
- ▶ A standardized contribution toward ‘living costs’ in residential care of £230 per week, that individuals will remain responsible for even after they have reached the ‘cap’.

However, potential downsides to the ‘capped cost’ model included in the Care Act (2014) gave rise to concern among some stakeholders, for example, relating to the partial nature of the ‘cap’ on costs, and the risk of unintended consequences, such as the potential erosion of ‘cross-subsidy’ in the residential care market.

More widely, since the ‘capped cost’ model was first proposed, substantial changes have occurred across health and social care policy, which significantly change the context for reform, including the growth of the integrated care agenda, the introduction of the National Living Wage and the ‘Freedom and Choice’ changes to private pensions.

Building on the principle that it is the responsibility of the state to cap people's lifetime care costs, a number of other broad options to designing entitlement to care funding can be identified. These options relate to capping:

- ▶ Years of residential care that people must fund;
- ▶ The cost of care annuities;
- ▶ The scope of social care means testing;
- ▶ Weekly expenditure on care;
- ▶ The price of care that people have to pay;
- ▶ The share of weekly care fees individuals must pay;
- ▶ The costs of providing unpaid care to families.

The analysis set out in this report suggests several conclusions:

- ▶ The capped cost principle is powerful and will survive regardless of changes in health and social care policy, or the fiscal context;
- ▶ Interim reforms before 2020 are possible drawing on this principle;
- ▶ Fiscal constraints are important but costs can be managed;
- ▶ The pause to implementation is an opportunity to adapt reforms to a changed policy context.

# 1. Introduction

## 1.1. Background

For many years, campaigners have called on the government to reform the system of funding adult social care in England given the uncertainty it poses for families, and unfairness for those individuals whose lifetime savings are used up paying for care.

In response, the Coalition government created the Commission on Funding Care and Support, chaired by Andrew Dilnot, which published its recommendations in July 2011.<sup>1</sup>

The ‘**capped cost**’ model put forward by the Commission was adopted by the Coalition in early 2013. The Commission’s proposals were built on the principle that it is the responsibility of the state to protect people from so-called ‘catastrophic’ care costs. Legislation required to implement the reforms was incorporated into the Care Act (2014), with full implementation scheduled for April 2016.

However, on July 17<sup>th</sup> 2015, the Department of Health published a letter from the Minister for Social Care to the Chair of the Local Government Association (LGA) stating that the reforms would be **postponed until April 2020**.<sup>2</sup> This letter noted:

“... The proposals to cap care costs and create a supporting private insurance market were expected to add £6 billion to public sector spending over the next 5 years. A time of consolidation is not the right moment to be implementing expensive new commitments such as this, especially when there are no indications the private insurance market will develop as expected.”

Following this announcement, social care campaigners have questioned whether the ‘capped cost’ reforms will be **postponed again before 2020** by the government, or **scrapped completely**.

Indeed, the two factors cited by the government as justification for postponing reform - a structural deficit in public spending and the absence of indications of a pre-funded insurance market – are also likely to be present in April 2020.

However, another scenario exists: **implementation of an alternative reform package during the current parliament based on the principle of capping people’s care costs**.

Such an approach would:

- ▶ Allow the government to meet its **political commitment** to cap people’s care costs;
- ▶ Enable a refreshed set of reforms to care funding in England that take account of recent **developments in health and social care policy**, and **avoid downsides** to the ‘capped cost’ reforms such as complexity and unintended consequences;

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<sup>1</sup> Commission on Funding Care and Support (2011) *Fairer Care Funding*, Department of Health, London

<sup>2</sup> Burt A (2015) *Letter to Cllr Izzi Seccombe, LGA*, Department of Health, London

- ▶ Address the **unfairness and uncertainty** that characterizes England’s care funding system.

## 1.2. Rebooting the Cap

This report explores how the government could take steps to cap people’s care costs during the current parliament. It examines the background to the government’s decision to postpone care funding reform, and explores what an alternative set of measures to cap people’s care costs could look like.

The next chapter explores the logic underpinning the principle that it is the **responsibility of the state to cap people’s care costs**. It reviews the operation of the current care funding system, the incidence of catastrophic care costs and the difficulties of private insurance companies in protecting people from this risk.

Chapter 3 summarises the **‘capped cost’ model** incorporated into the Care Act (2014) and **limitations** to the reforms highlighted by stakeholders, such as its complexity and potential for unintended consequences.

The fourth chapter sets out the **trends in health and social care policy** that have emerged since 2011, and their implications for reform of adult social care funding. Against this context, it explores the different options available to the government for capping people’s care costs.

Chapter 5 concludes the report with **key messages** for policymakers.

# 2. Why should the state cap people's care costs?

## 2.1. Introduction

This chapter explores:

- ▶ **How does the current system for funding long-term care in England operate?**
- ▶ **What underpins the principle that the state should cap people's care costs?**

## 2.2. How does the current system for funding long-term care in England operate?

Most people with care needs rely on unpaid care from family or friends. However, many people with personal care and support needs receive support from paid carers. This paid care may be:

- ▶ **Domiciliary care** in a person's own home, or;
- ▶ **Residential care** in a care home, nursing home or extra care facility.

In England, financial support from the state for care costs is administered by local authorities, who have a duty of care toward their local population. Local authority support for care costs is rationed through the application of two eligibility criteria:

### ▶ **Needs**

To qualify for local authority support for care costs, a person must be assessed as having **eligible care needs**. These are needs resulting from a person being unable to undertake 'activities of daily living' – for example, dressing and eating - such that there is a risk to their wellbeing. The availability of adequate unpaid care from family and friends will normally disqualify individuals from having eligible care needs met by their local authority.

### ▶ **Financial means**

If someone is assessed as having qualifying care needs, a local authority will determine the financial value of care they are judged to require, and then undertake a means assessment to determine how much of this amount individuals must contribute themselves.

Local authority means tests take account of a person's **income and wealth**. For domiciliary care, the means assessment excludes the value of someone's home. However, in determining support for residential care costs, **local authorities will include the value of people's homes as 'assessable wealth'** for the purposes of the means test, if no other close relative is living there.

Across both domiciliary and residential care, individuals with more than £23,250 in 'assessable wealth' are required to meet the costs of their care on their own. Individuals with assessable wealth between £14,250 and £23,250 are expected to make a contribution to their

care costs from their wealth in addition to their income. Those with assessable wealth below the £14,250 threshold will have it disregarded by the means test, but may still be expected to contribute to their assessed care costs from their income.

Crucially, many individuals with private care needs are expected to shoulder very large care costs themselves. These are typically individuals who move into residential care, leaving behind a vacant home that they own. The value of this home can frequently be far above the £23,250 local authority means test threshold, and these individuals are expected to use up most of the value of this home to fund their care before they become entitled to local authority financial support.

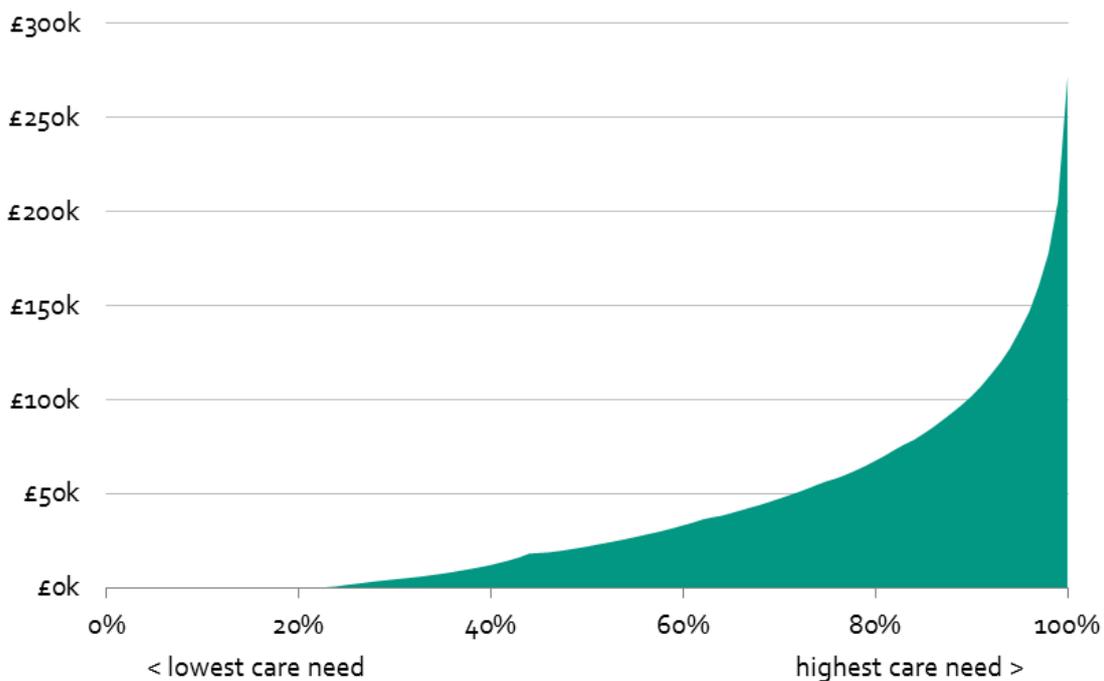
### 2.3. What underpins the principle that the state should cap people’s care costs?

For many years, campaigners have argued England’s care funding system requires reform because of the significant accumulated care costs that some individuals confront.

Although some individuals never have any need for care during their lifetime, among those who do come to rely on paid care at home or in a residential care home, the **accumulated costs of care can run to several hundred thousand pounds**. For example, someone paying £750 per week for residential care will spend £136,500 over three years.

As a result, individuals confront **uncertainty and risk in relation to their total lifetime care costs**. The following chart illustrates these differences in people’s experiences. It shows the expected lifetime costs of care for all individuals aged 65 and over in England, regardless of whether this is funded by the state or individuals themselves.

**Expected future lifetime costs of care for people aged 65 in 2009/10, by percentile (2009/10)**



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

On the left of the chart, some individuals (over 20% of the population) never use any paid care, so have expected lifetime care costs of £0. Looking gradually further to the right of the chart, some individuals are projected to have lifetime care costs of a few thousand pounds. Around the middle of the chart, the median individual can expect lifetime care costs of around £25,000 in 2009-10 values – or around £32,250 in today's prices.<sup>3</sup>

On the far right of the chart are individuals with expected lifetime care costs of hundreds of thousands of pounds. These are individuals who go on to experience high levels of care need and live in residential care for an extended period.

The chart shows that **the 2% of individuals with the highest expected lifetime costs can expect care costs in excess of £200,000** (around £242,000 in today's prices). Depending on financial circumstances, **individuals may be expected to meet these costs entirely by themselves**, owing to the nature of state support and the operation of local authority means tests.

### The principle of capping people's care costs

How can people be protected from the risk of experiencing catastrophic care costs?

In designing public policy, governments can seek to insure individuals against risk in one of two basic ways:

- ▶ Taxation/'social insurance' – in which risk is pooled via the state through compulsion, sometimes with both contributions and people's entitlement proportional to their financial means;
- ▶ Private insurance – in which insurance companies offer products that people can purchase on a voluntary or compulsory basis, with premiums usually determined by a person's individual risk profile.

Crucially, **private insurance companies cannot sustainably offer pre-funded insurance against catastrophic care costs**. As a result, in countries where pre-funded insurance products have been offered, insurance companies have been forced to impose extremely high premiums for policies, as well as conditional or limited coverage, making products to unattractive to consumers and contributing to **market failure** in many places. For example, a recent report notes that in the United States, few private companies will insure against risks of 10 years or more and are increasingly capping their risk at five years, with the result that sales of individual policies have fallen by 80% during the last decade.<sup>4</sup>

Why do insurance companies struggle to offer protection to individuals against very high lifetime care costs? This is because of the **actuarial (risk) characteristics of disability and life expectancy**. Insurance companies can estimate the probability that someone will experience a particular type of disability during their lifetime. However, it is extremely difficult for insurance companies to estimate how long someone will live with a disability before that

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<sup>3</sup> Uprating for consumer price inflation undertaken using the Bank of England's inflation calculator.

<sup>4</sup> Convergence Center for Policy Resolution (2016) *Long-term Care Financing Initiative*, Washington DC

person has actually begun to experience the disability.

As a result, insurers struggle to sustainably offer simple pre-funded insurance in relation to long-term care that protects people against catastrophic care costs.

This results in an important moral and practical consequence for policymakers: **if individuals are to be protected from incurring catastrophic social care costs, only the state can offer this protection.**

In this way, the logic underpinning the principle that the state should protect people from catastrophic care costs becomes clear: **it is the responsibility of the state to offer such protection because there is no sustainable private insurance alternative.**

# 3. The ‘capped cost’ reforms

## 3.1. Introduction

The Commission on the Funding of Care and Support published its recommendations for a ‘capped cost’ funding system in 2011, building on the principle that it is the responsibility of the state to offer such protection

In 2013, the government agreed to take the reforms forward, promising full implementation by April 2016. But, in July 2015, the government announced implementation would be postponed until April 2020. The government cited two key factors for this postponement:<sup>5</sup>

- ▶ Fiscal pressures and the need to cut public spending;
- ▶ The absence of any evidence that a complementary, pre-funded private insurance market was developing.

However, there were **other reasons for the government not to press ahead with implementation** of the ‘capped cost’ reforms - including limitations to the reforms that gave rise to concerns among stakeholders - which are also relevant to understanding the government’s decision to postpone.

This chapter therefore explores:

- ▶ **What did the ‘capped cost’ reforms propose to do?**
- ▶ **What are the limitations to the ‘capped cost’ reforms included in the Care Act (2014)?**

## 3.2. What did the ‘capped cost’ reforms propose to do?

Taking the principle that it is the responsibility of the state to cap people’s lifetime care costs as its foundation, the Commission on Funding of Care and Support proposed the ‘capped cost’ model of care funding as the basis for reform in the English care system.

The reforms built on the existing system of local authority care funding in England, including the central role of **needs and means assessments**.

The ‘capped cost’ reforms, which were subsequently incorporated into the Care Act (2014), have several core components:

- ▶ **A cap of £72,000 on the assessed, eligible lifetime care costs that adults are expected to meet**

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<sup>5</sup> Burt A (2015) *Letter to Cllr Izzi Seccombe, LGA*, Department of Health, London

Individuals with eligible care needs, but who are not eligible for full local authority support for their assessed costs following a means assessment, will be expected to spend no more than £72,000 during their lifetime toward the financial value of their eligible care costs.

This cap on costs does not relate to all care costs that a person may incur, but only in relation to assessed care costs agreed by the local authority resulting from eligible care needs.

- ▶ **An increase in the upper capital threshold for residential care from £23,250 to £118,000 for people living in a care home whose property has not been disregarded from the means test**

Under the current care funding system, individuals in residential care with assessable wealth above the local authority means test threshold of £23,250 would be expected to meet the costs of care entirely on their own. However, an increase in the upper wealth threshold of the means test to £118,000 would see individuals with wealth between £14,250 and £118,000 also entitled to a means test and - potentially - financial support from the local authority for their assessed care costs.

In this way, the ‘capped cost’ reforms would offer increased support for care costs to individuals with levels of wealth below the £118,000 threshold.

- ▶ **A standardized contribution toward ‘living costs’ in residential care of £230 per week, that individuals will remain responsible for even after they have reached the ‘cap’**

Regardless of someone’s income, for the purposes of a local authority means test, the first £230 cost of their weekly residential care fees would qualify as ‘living costs’ – the notional ‘board and lodging’ cost of residential care – rather than as care costs.

### **3.3. What are the limitations to the ‘capped cost’ reforms included in the Care Act (2014)?**

Despite the careful consideration given to the different components of the ‘capped cost’ model, potential downsides to the reforms included in the Care Act (2014) gave rise to concern among some stakeholders, providing the government with another motivation for postponing implementation.

These stakeholder concerns are briefly summarised below, and set out in more detail in the Appendix:

- ▶ **The partial nature of the ‘cap’ on costs**

The ‘cap’ would not actually cap people’s costs. People paying independently for care privately typically pay more than local authorities for equivalent care. However, because the ‘eligible costs’ recorded in the ‘capped cost’ model are pegged to what the local authority would pay, self-funders would pay more than the value of the ‘cap’ before they reached it, and would have to make additional payments beyond it. This would potentially lead to

disappointment and frustration among care users and families, and wider disengagement with the reforms.

▶ **Complexity and peace of mind**

The overall complexity of the reforms, and the various caveats and assumptions in the ‘offer’ they represent for the public would potentially undermine any peace of mind benefits to the population.

▶ **Value for money**

The additional administrative costs posed by the reforms mean the ‘capped cost’ model may not represent good value-for-money for public spending. In fact, an official government analysis of the costs and benefits of the reforms was only able to derive a positive net-benefit figure given the additional administrative costs by making very optimistic assumptions about the notional financial value of the peace of mind benefits to the population.<sup>6</sup>

▶ **The uninsurable nature of the people’s liability for private care costs under the ‘cap’**

In actuarial terms, the £72,000 of notional costs that individuals are left with under the ‘capped cost’ model is uninsurable, i.e. determined by factors that insurance companies cannot accurately model or predict. As a result, it is very unlikely that any complementary pre-funded insurance products would ever be introduced by private insurance companies.

▶ **Risk of unintended consequences**

Two potential unintended consequences resulting from the reforms have received particular attention. By exposing the difference between fees payable by self-funders and local authorities, the ‘capped cost’ reforms may have acted to erode the cross-subsidy that operates in the residential care market, threatening the financial sustainability of both care providers and councils.

In addition, in some parts of the country, large sections of care users would be at or around the new, higher £118,000 means test threshold, providing a strong incentive to engage in so-called ‘deliberate deprivation’, whereby families seek to ‘game’ the local authority means test in order to increase their entitlement to financial support.

▶ **Inconsistency and variation**

Various aspects of the ‘capped cost’ reforms would in practice be characterised by inconsistency and variation. For example, the time taken to reach the ‘cap’ would vary between around 3.5 to 10 years across different parts of the country. The real, actual level of wealth that self-funders of residential care would have to have, to be entitled to local authority financial support, would also vary widely across different areas despite the single £118,000 threshold.

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<sup>6</sup> Department of Health (2015) *Social Care Funding Reform Impact Assessment*, Department of Health, London

# 4. Capping Care Costs: The context and options in 2016

## 4.1. Introduction

The government's 'capped cost' reforms were built on the principle that it is the responsibility of the state to protect people from catastrophic care costs. However, as the previous chapter noted, the 'capped cost' reforms included in the Care Act (2014) led to a range of concerns among stakeholders.

Despite such concerns, and the factors that contributed to the postponement of the 'cap', the **government remains politically committed to social care funding reform and the principle that the state should cap people's care costs.**

As such, the government could consider implementation of an **alternative reform package** during the current parliament based on the principle of capping people's care costs. This would enable the government to adapt its programme for long-term care funding reform in England to recent developments in health and social care policy, and address some of the concerns of stakeholders with the 'capped cost' model.

This chapter therefore explores:

- ▶ **What developments in health and social care policy have changed the context for implementing reform?**
- ▶ **What are the alternative options for capping people's care costs?**

## 4.2. What developments in health and social care policy have changed the context for implementing reform?

The Commission on Funding of Care and Support was launched in July 2010 and issued its recommendations in July 2011.

However, five years later, substantial changes have occurred across health and social care policy, which significantly change the context for the future introduction and operation of the reforms to adult social care funding in England.

### ▶ **Integrated care**

There is wide-ranging consensus across the health and social care systems that there should in future be more **integrated care**. Multiple models of integrated care exist, and usually relate to the integration of health and social care **funding, commissioning or delivery**.

For example, the Greater Manchester Combined Authority, comprising local authorities in and around Manchester, has launched new decision-making bodies made up of representatives

from the NHS and local authorities, and begun to take responsibility for the £6 billion budget that is spent on services such as hospitals, GP surgeries, mental health and social care across the region. The objective is for local leaders and clinicians to be able to design services to directly meet the needs of local communities.<sup>7</sup>

Such profound changes, which are set to be repeated in other parts of the country, create scope for the merging of health and social budgets, and ultimately, single integrated health and care providers that do not distinguish between a person's health and care needs.

However, a consequence of such changes is that there are **significant questions around how 'social care' will be defined in future, which local bodies will assess and determine social care 'needs'** and how services will be provided.

These trends raise questions for the future of care funding reforms, which are **predicated on the preservation of the current system** of local authority social care needs and means assessments. For example, if the government implemented the 'capped cost' model at significant expense, only to move to a new social care system more coherent with integrated care, this would potentially represent a waste of public expenditure.

#### ▶ **National Living Wage**

In the July 2015 Budget, HM Treasury announced the introduction of a "National Living Wage", comprising a mandatory increase in the National Minimum Wage.

It has been estimated that the National Living Wage will increase payroll costs associated with frontline care workers by £2.3 billion by 2020, on top of £1.7 billion of costs already implied by above-inflation increases in the National Minimum Wage.<sup>8</sup>

These changes have been welcomed as a key step to improving quality in the care system. However, local authorities and care providers confront considerable unforeseen additional workforce costs in future.

This has resulted in widespread concern that the government will not ensure adequate funding for local authorities to finance both the increase in the National Minimum Wage, and the additional costs of reform to long-term care funding. More broadly, it has raised questions around how much public spending on social care should be focused on reforms to care funding, as opposed to workforce costs, during the parliament.

#### ▶ **The social care 'precept'**

The November 2015 Autumn Spending Review announced local authorities with responsibility for adult social care would be given the power to raise new Council Tax funding exclusively for social care.<sup>9</sup>

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<sup>7</sup> Source: <http://www.gmhealthandsocialcaredevo.org.uk>

<sup>8</sup> Gardiner L (2015) *Care to pay? Meeting the challenge of paying the National Living Wage in social care*, Resolution Foundation, London

<sup>9</sup> HM Treasury (2015) *Spending Review and Autumn Statement 2015*, London

The so-called social care ‘precept’ will enable local authorities to increase Council Tax in their area year on year by up to 2% above the existing threshold. HM Treasury has estimated that if all local authorities use the social care precept to the full, this would raise nearly £2 billion a year by 2019-20.

Although some stakeholders have raised concerns around the adequacy and implications of the social care ‘precept’, its introduction nevertheless represents an historic change in government policy, both in relation to new funds being raised and the introduction of hypothecated taxation specifically for social care.

However, the precept also raises questions for long-term care funding reform and the ‘capped cost’ model; for example, over whether it remains appropriate for entitlements to local authority social care funding to remain the same in all areas, when only some councils are raising additional taxation.

### ▶ ‘Freedom and Choice’ changes to private pensions

In April 2015, the government implemented historic changes to rules on private pension savings. Savers aged 55 and over with Defined Contribution (DC) pension savings were released from any obligation to use these savings to provide a guaranteed pension income, which for most people had previously meant purchasing an annuity. Instead, DC savers are now able to take their savings as cash or as income drawdown, in addition to purchasing an annuity, paying only their marginal rate of income tax on any withdrawals from their pension savings.

A growing percentage of savers are reaching retirement with only DC pension savings, as the UK gradually transitions away from traditional, ‘final-salary’ Defined Benefit (DB) pension provision. However, there is huge uncertainty around how retirees will respond to the new rules, what the Freedom and Choice changes will mean for pensioner incomes in future, and what the consequences of the new arrangements will be for the local authority means tested social care system.

For example, what proportion of future retirees will have used up their pension savings before needing care, thereby increasing their entitlement to local authority support? Given the central role of means testing, will retirees who place their DC savings in cash or drawdown transfer this wealth to family members before requesting a local authority needs assessment, in order to increase their entitlement to support? The Association of British Insurers has estimated that during the first year of the new DC pension rules, around £5.9 billion was withdrawn, much of which would otherwise have been converted into guaranteed incomes that would have been taken account of in local authority means tests.<sup>10</sup>

The fundamental consequence of the Freedom and Choice changes for long-term care funding reform is therefore to make it much **harder to estimate the additional costs of reform over five to 20 years**, given uncertainty around how DC savers will respond and trends in the income and wealth profile of retirees who seek support from their local authority.

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<sup>10</sup> ABI (2016) *ABI publishes latest data one year on from pension freedoms – reforms ‘settling in and working as intended’*, <https://www.abi.org.uk/News/News-releases/2016/03/ABI-publishes-latest-data-one-year-on-from-pension-freedoms-reforms>

### **4.3. What are the alternative options for capping people's care costs?**

Building on the principle that it is the responsibility of the state to cap people's lifetime care costs, a number of other broad approaches to designing entitlement to care funding can be identified that draw on this principle. Some would seek to explicitly cap the care costs of people who need expensive care for many years. Others would increase protection from catastrophic care costs by reducing the rate at which people spend down their wealth on care, cutting everyone's chances of experiencing catastrophic costs.

Different options have different pros and cons, and would present the government with a wide range of potential costs, depending on how they were implemented. Some could be implemented as 'stepping stones' toward the 'capped cost' model, or as a replacement to it. The options could be implemented in isolation, or in combination with other options.

#### **▶ Capping years of care**

The 'capped cost' model requires a complex administrative system to determine, record and monitor people's notional private care costs. Nevertheless, the reforms would result in wide variations in different parts of the country in how long it would take individuals to reach the 'cap'.

As either an alternative or a 'stepping stone' measure, the government could implement a 'years of care' cap on people's residential care costs, whereby self-funders of residential care with qualifying needs would be entitled to their local authority average rate for care after a fixed period, for example, four years.

This model would be simple to understand, impose negligible additional administrative costs and provide high levels of consistency and predictability across the country, compared to the 'capped cost' reforms. The cost to the Exchequer would depend on how many years in residential care that individuals were expected to pay for privately.

Issues to consider for this model would be whether self-funders in more expensive areas of the country – or those requiring more expensive care - would have to pay more before they reached a 'years of care' cap than those in cheaper areas, and how to ensure that it did not encourage people to choose residential over domiciliary care. In addition, given the benefits of a 'years of care' cap would mostly accrue to wealthier households, the government might nevertheless want to consider increases to means test thresholds similar to those included in the 'capped cost' model, so that the overall distribution of extra spending on support for care costs also benefitted poorer households to a reasonable extent.

#### **▶ Capping the cost of care annuities**

Although no UK insurance companies offer pre-funded care insurance, a small number of companies do offer 'immediate needs annuities'. These are insurance policies bought at the point that someone enters residential care. In return for a significant, up-front premium, the annuity will pay a regular income toward someone's care fees for the rest of their life, regardless of how long they ultimately live for.

The cost (premium) of immediate needs annuities varies widely, depending on a person's life expectancy at the point of going into residential care. The government could increase protection from catastrophic care costs by offering to cap the price (premium) of a person's immediate needs annuity, relative to the income to be paid out.

For example, if an immediate needs annuity paying average market-rate fees for a typical individual cost £75,000, local authorities could cap the cost of a premium that individuals have to pay for privately at £85,000: if individuals are quoted a higher premium than this threshold for an immediate needs annuity, the authority would pay the extra cost.

In this way, the government would be able to say that where individuals opted to purchase an immediate needs annuity, for average care home fees, their total care costs would be capped at £85,000.

This model would afford greater financial protection to those who are likely to live longest in residential care, for example, individuals with Alzheimer's disease, who would otherwise confront the highest premiums for purchasing an immediate needs annuity. A variant of this model would see local authorities co-pay a fixed percentage of any immediate needs annuity premium that individuals were offered, capping potential expenditure in this way.

Nevertheless, it is important to note that there are a number of consumer challenges for insurers in selling immediate needs annuities, which have limited growth of the market. As such, although the government could cap the price that people have to pay for an immediate needs annuity, its likely take-up would remain small. This would, however, also limit the cost to the government of making this guarantee to the public.

#### ► **Capping the scope of social care means testing**

The means tested social care system in England operates alongside the NHS, and the border between the two systems is a source of ongoing dispute and debate, especially in relation to what constitutes health versus care needs, and which public agencies are responsible for funding the support of individuals with complex conditions.

By redefining the scope of social care needs and what individuals are expected to pay for privately, the incidence of catastrophic care costs for individuals could be reduced. Redrawing this boundary by reclassifying some social care needs as health conditions would result in a narrower range of conditions and support types that are defined as 'social care', and would serve to reduce lifetime expenditure on care and increase protection from catastrophic care costs.

For example, support for personal care needs arising from Alzheimer's disease could be incorporated into the responsibilities of the NHS, reducing the potential social care costs facing families.

Redrawing boundaries between health and care needs in this way would be popular with some families, would cap what support individuals have to pay for privately, but would nevertheless preserve disputes around what is a health or care need, and may ultimately be problematic in the context of integrated care.

### ▶ **Capping weekly expenditure on care**

To provide greater peace of mind to the population, the government could cap the amount that individuals are expected to pay toward their care each week.

This model already operates in Wales, where the maximum amount councils can charge individuals for all domiciliary (non-residential) social services is £60 per week. Local authorities fund the remaining assessed care costs.

A weekly cap on private expenditure on care in England would be a tangible, clear framework for the public, and may improve peace of mind in the population. It could apply to domiciliary and/or residential care, and would reduce lifetime expenditure on care thereby increasing protection from catastrophic care costs.

However, the distributional consequences of a cap on weekly expenditure are significant: the largest proportion of the extra spending required to achieve a weekly cap on costs is directed at those most able to pay, i.e. the wealthiest. As such, additional changes to means test thresholds may be required to improve the distribution of protection across different income and wealth groups.

### ▶ **Capping the price of care**

The government could introduce regulations to cap the price of residential care relative to the quality of accommodation provided and provider costs, thereby reducing the amount that families pay for care and increasing protection from catastrophic care costs.

The residential care system in England mostly comprises independent sector provision, from both the charitable and private sectors. Providers of care are free to set their prices as they wish, and local markets are characterised by significant price variation and price discrimination, i.e. different customers are charged different amounts for broadly similar services.

Capping the price of different 'bands' of care home would introduce significantly more consistency and transparency into the market, and reduce the incidence of catastrophic costs accruing to individuals through care homes charging high fees, thereby increasing protection from catastrophic costs.

However, regulations to cap the price of care would be challenging to enforce and judgements could be subject to legal challenge by providers. For example, care home providers may challenge their 'banding' and seek to game the assessment system. In addition, care homes of a similar quality of accommodation may have significantly varied costs, such that some homes may actually continue to charge more than they need because the regulated price in their area for their banding takes account of homes with more expensive running costs.

### ▶ **Capping share of fees people have to pay**

Rather than capping the weekly amount that people have to pay in charges for means tested care, the government could instead cap the proportion – or share – of people's assessed care

costs that they have to pay for privately. For example, the government could commit to no one having to pay more than two-thirds of their assessed care costs privately, thereby reducing lifetime expenditure on care and increasing protection from catastrophic care costs.

The principle reflected in this approach – everyone should receive something, proportional to means – underpinned the ‘partnership model’ put forward by the Wanless Social Care Review,<sup>11</sup> and would see all individuals receiving, for example, around one third of their assessed care costs from their local authority.

However, such an approach would have the potential to be expensive to the Exchequer. It is also unclear how much reassurance the model would offer to the public, since few people have a clear understanding of how much different types of care can cost. In addition, given many individuals pay more for residential care than a local authority, many self-funders could in fact find that the local authority contribution amounts to less than one-third of their fees.

### ► **Capping the costs of caring**

Most care and support is unpaid, ‘informal’ care provided by family and kin. As such, for many people, the most worrying potential costs of care are those associated with taking on significant informal caring responsibilities for an extended period.

The government could seek to cap the costs of informal caring for individuals and families. Since many carers experience lost earnings, the government could consider a deferred income-replacement scheme to cap the cost of lost earnings, whereby after a fixed period, carers would begin to receive a paid salary proportional to their previous earnings. Alternatively, the government could roll over tax-free Personal Allowance that was unused owing to informal caring, allowing people to earn back through tax-free salary the income foregone as a result of caring.

Such measures would interpret more broadly the ‘costs of caring’, but in a way that is pertinent to many people’s experience of care and worries regarding it.

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<sup>11</sup> Wanless D et al. (2006) *Securing Good Care for Older People*, The King’s Fund, London

# 5. Conclusion

## 5.1. Improving protection from catastrophic care costs

This report has explored why it is the responsibility of the state to protect people from catastrophic social care costs, the background to the government's decision to postpone the implementation of the 'capped cost' reforms, and some alternative options for capping care costs that could be implemented during the current parliament.

On the basis of this analysis, a number of conclusions can be drawn.

### ▶ **The capped cost principle is powerful**

Health and social care policy has changed significantly since 2011, when the 'capped cost' model was first put forward by the Commission on Funding of Care and Support.

However, the need to protect people from catastrophic care costs has not declined. Indeed, because of underlying actuarial factors, the logic underpinning the principle that it is the responsibility of the state to protect people from catastrophic care costs will survive regardless of changes in health and social care policy, or the fiscal context.

This report has explored the limitations of the 'capped cost' model included in the Care Act (2014), but has also shown that multiple alternative options for fulfilling its responsibilities are available to the government.

### ▶ **Interim reforms are possible**

As it considers the future of long-term care funding reform in England, the choices facing the government are not 'either/or' in nature. Rather, whether or not the government does ultimately implement the 'capped cost' reforms in full, the government can proceed with interim, stepping-stone reforms that increase protection for care users and families. The decision to postpone implementation of the 'capped cost' reforms to April 2020 does not mean the government cannot proceed with other reforms in the interim, such as a 'years of care' cap, or a cap on the amount individuals must spend on an immediate needs annuity.

### ▶ **Fiscal constraints are important but costs can be managed**

In announcing its decision to postpone reform, the principal reason cited by the government was public spending pressures and deficit reduction. Fiscal constraints to care funding reform in England are clearly important, but the costs of reform can be managed.

Indeed, some alternative reform options – such as a time-based cap on residential care costs – may pose negligible implementation costs and could be made as (in)expensive as the government wished.

▶ **Pause is an opportunity to adapt reforms to changed context**

The 'pause' to care funding reform in England provides an opportunity to adapt and rethink reforms, taking account of changes and developments in health and care policy, such as the growth of integrated care. Care funding reforms that were right in 2011 may no longer be a good fit in 2020 and beyond. The current parliament therefore gives the government an opportunity to think again about how best to fulfil its responsibility to protect people from catastrophic care costs.

▶ **Not re-thinking reform could be risky**

By April 2020, the health and social care systems will have changed substantially from July 2011, when the Commission on Funding of Care and Support first put forward the 'capped cost' model.

Given radical innovations currently unfolding, such the pooling of health and care funding across Manchester, it is important that reform of care funding takes account of likely changes and seeks to be compatible with them. Crucially, not re-thinking and refreshing reform of care funding could result in a substantial waste of public money. If the 'capped cost' model were implemented in April 2020, but in the summer of 2022, the government implemented a radical devolution and integration of health and care funding across England, this would potentially make it unfeasible to continue operating the 'capped cost' model.

The observations underscore the risk to the government and Exchequer of failing to use the period up to April 2020 to review, rethink and potentially refresh care funding reform in England.

# 6. Appendix

**This Appendix expands on the analysis contained in Chapter 3 by setting out in more detail limitations to the ‘capped cost’ reforms that had given rise to concerns among stakeholders.**

## **6.1. The partial nature of the ‘cap’ on costs**

Since 2011, multiple stakeholders have pointed out that the ‘cap’ is not in fact a cap on care costs, owing to the difference between the amount that self-funders typically pay for residential care and local authority average fee rates.

In particular, this difference would ensure that most self-funders in residential care would have paid significantly more in care fees before reaching the ‘cap’, and would go on paying a ‘top-up’ beyond it. In fact, for many self-funders of residential care, the notion of a ‘cap’ would be misleading as they would become entitled – in effect – only to a fairly generous ‘co-payment’ upon reaching the £72,000 threshold.

This has resulted in concern among some stakeholders as to how the ‘cap’ on costs would ultimately be perceived, whether it was potentially misleading, and who within the care system – such as social workers or care home managers – would ultimately be responsible for explaining to care users and families how their care costs would not be capped.

## **6.2. Complexity and peace of mind**

Previously, the government has framed ‘peace of mind’ as a key benefit to the population from implementation of the ‘capped cost’ funding reforms. However, as local authorities and care providers began preparations for implementation of the ‘capped cost’ reforms, it became clear that many people working in the social care system struggled to understand the changes, casting doubt on whether the public would ever satisfactorily comprehend the new system. This reflects the complexity of the reforms, and the considerable caveats, assumptions and simplifications inherent in presenting the ‘capped cost’ reforms as actually capping lifetime care costs.

As such, some stakeholders have argued that the ‘capped cost’ reforms are excessively complex in nature, and that this complexity would ultimately undermine the benefits of the reforms, such as encouraging peace of mind in the population.

## **6.3. Value for money**

The government’s analysis of public spending on the ‘capped cost’ reforms suggests the measures may not represent value-for-money.

In a cost-benefit analysis of the reforms, the Department of Health split the financial benefits of the reforms into: direct financial transfers (support for care fees); and, the additional ‘peace

of mind' benefits generated for the population. The financial costs of the 'capped cost' reforms were projected to significantly exceed the value of financial transfers to individuals because of the additional means testing and administration necessitated by the reforms.

However, the government's cost-benefit analysis derived an overall net-positive figure – benefits that exceed costs - for the 'capped cost' reforms by estimating 'peace of mind' benefits to the population worth £5.65 billion over 10 years (2016/17 prices).<sup>12</sup>

This estimate was based on a methodology that used data on private care insurance in the USA to estimate the financial value of the peace of mind benefits that individuals attribute to insurance. The government's analysis acknowledges that such an approach is subject to several caveats and assumptions, for example, assuming people in England having similar risk preferences (for social insurance) to citizens in the USA (for private insurance), and the assumption that each pound of risk that the state covers is of a constant value to the individual. Indeed, this methodology can be challenged in multiple ways, not least because there is no evidence to suggest that the people in the UK would be able to understand the 'capped cost' reforms in practice, and thereby derive 'peace of mind'.

As such, the government's own cost-benefit analysis of 'capped cost' reforms suggests they may not represent value-for-money owing to their administrative costs.

#### **6.4. The uninsurable nature of people's liability for private care costs under the 'cap'**

In committing to the 'capped cost' model in 2011, the government hoped this would stimulate the creation of complementary pre-funded care insurance products. However, it has become clear that no insurance companies planned to offer such products in the wake of the reforms, as the Minister for Social Care noted in his July 2015 letter to the LGA.

Indeed, a BBC survey of 17 insurance companies providing anonymous responses that was published in January 2015 revealed none planned to introduce pre-funded products in response to the implementation of the reforms.<sup>13</sup>

No country in the world has a healthy or growing market in pre-funded long-term care insurance, and there is an extensive academic literature exploring this market failure.<sup>14</sup>

Although the 'capped cost' reforms would provide some protection to individuals from catastrophic care costs, previous analysis suggests there is nothing about the reforms that would make the emergence of a pre-funded care insurance market more likely, not least because the £72,000 liability for care costs that individuals are left with under the scheme is actuarially uninsurable.<sup>15</sup>

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<sup>12</sup> Department of Health (2015) *Social Care Funding Reform Impact Assessment*, Department of Health, London

<sup>13</sup> Trigg N and Woodcock S (2015) *Companies report 'no interest in care insurance'*, BBC News Online, London, see: <http://www.bbc.co.uk/news/health-31023340>

<sup>14</sup> Lloyd J (2011) *Gone for Good? Pre-funded insurance for long-term care*, Strategic Society Centre, London

<sup>15</sup> Lloyd J (2011) *The First Step? A response to the Commission on Funding of Care and Support*, Strategic Society Centre, London

Crucially, the change in government policy announced in July 2015 in relation to the ‘capped cost’ reforms has underscored the political risk and uncertainty facing insurance companies who might consider pre-funded care insurance products, which may further reduce the probability of products being forthcoming in future.

## 6.5. Risk of unintended consequences

Various potential unintended consequences were identified in relation to the Care Act (2014) and the ‘capped cost’ funding reforms.

### ▶ Cross-subsidy in the residential care market

Since announcing its commitment to the ‘capped cost’ care funding reforms in 2013, there has been growing concern among local authorities and residential care providers that the interaction of different components of the reforms would crystallise, and ultimately erode, the ‘cross-subsidy’ in the residential care market. This cross-subsidy results from price discrimination by care home providers – charging higher fees to self-funders compared to local authorities – and enables councils to pay lower rates, owing to the ‘premium’ paid by private self-funders.

In the face of such concerns, the County Councils Network (CCN) commissioned research that estimated that the ‘care home fee gap’ among its member councils was worth £630m during 2014.<sup>16</sup> The CCN argued that an unforeseen consequence of the implementation of the Care Act was that this figure would rise to £756m by 2016-17, with the Act indirectly creating further sustainability risks through a process of ‘market equalisation’. The research authors, Laing & Buisson, estimated the cost of fixing the problem in county care markets alone would reach £3.1bn by the end of the 2015 to 2020 parliament.

### ▶ Gaming of the means tests

Some stakeholders have raised concerns that an increase in the upper capital threshold for residential care to £118,000 would cause a marked increase in so-called ‘deliberate deprivation’, i.e. gaming of the local authority means test.

In particular, in areas of England with lower house prices, a large proportion of the population may expect to enter residential care with total assets just above or under the £118,000 threshold. For example, research from the Strategic Society Centre published in 2013 found that in the North East, around 60% of older people living at home with limited day-to-day activities had total net housing and financial wealth below the £118,000 upper capital threshold. The equivalent figure for the South East was around 17%.<sup>17</sup>

As such, a potential unintended consequence of the ‘capped cost’ reforms in less well-off parts of the county could be a substantial increase in gaming of the local authority means test, whereby individuals transfer some of their assets to relatives in order to reduce their overall

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<sup>16</sup> Laing & Buisson (2015) *County Care Markets: Care Market Sustainability & the Care Act*, County Councils Network, London

<sup>17</sup> Lloyd J and Ross A (2013) *The Bigger Picture: Understanding disability and care in England’s older population*, Strategic Society Centre, London

level of wealth and increase their entitlement to local authority support. Such an outcome may occur because individuals with wealth levels close to the range of means tested support only need to transfer a small amount of their assets in order to achieve a direct increase in the potential value of local authority support they are entitled to.

## 6.6. Inconsistency and variation

Although the ‘capped cost’ reforms seek to make support for care costs predictable and consistent, the operation of the measures would actually involve substantial local variations and inconsistency.

### ▶ The time to reach the ‘cap’

The amount of time it would take for a self-funder in residential care to reach the £72,000 ‘cap’ on care costs would vary considerably, owing to variations among local authorities in the ‘rate’ they used to measure people’s care costs. This rate varies from around £330 per week to £750 per week in different parts of the country. As a result, the time it would take to reach the ‘cap’ would vary from around 3.5 to 10 years across different regions.<sup>18</sup>

### ▶ The ‘real’ local means test

Although the ‘capped cost’ reforms would see the upper capital threshold for residential care increase to £118,000, the ‘real’ effective threshold to means tested support – when individuals become entitled to financial support - would vary considerably among local authorities, even for individuals with identical income and wealth characteristics. Again, such differences reflect differences in the ‘local authority rate’ across different areas, and its role in determining people’s assessed care costs and whether or not they are entitled to financial support for residential care fees.<sup>19</sup>

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<sup>18</sup> Lloyd J (2013) *A Cap that Fits*, Strategic Society Centre, London

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