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Caps, Opt-ins, Opt-outs

Is England making progress in reforming care funding?

James Lloyd

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The Strategic Society Centre
145-157 St John Street
London EC1V 4PY

info@strategicsociety.org.uk
www.strategicsociety.org.uk

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About the Author

James Lloyd was appointed Director of the Strategic Society Centre in September 2010. He read Philosophy at University College London, and has Masters degrees in Comparative Politics and in Public Policy. James has worked at a number of Westminster and academic think-tanks, and at the Prime Minister's Strategy Unit. He has a particular interest in social care, assets and wealth, pensions and ageing. His previous publications include 'A National Care for Long-term Care', 'Asset Accumulation in Focus: The Challenges Ahead' and 'The Roadmap: England's Choices for the Care Crisis'. James is an Advisor to the ESRC Research Centre on Micro-Social Change at the University of Essex.

james.lloyd@strategicsociety.org.uk

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Executive Summary

The government accepts as the basis for reform of care funding in England the principle put forward by the Commission on Funding of Care and Support: financial protection through capped costs and an extended means test. However, the government will not make a decision on the 'capped cost' model until the next Spending Review, and wants to explore alternative ways of applying this principle in practice, beside the 'capped cost' model. Progress toward care funding reform may now occur in several ways: public acceptance of the difficult tax and spending decisions required to make the 'capped cost' model cost-neutral for the Treasury; the implementation of a low-cost 'capped cost' model, or the creation of a voluntary 'capped cost' state-sponsored insurance scheme, that becomes mandatory over time.

This discussion paper provides analysis of "Caring for our future: progress report on funding reform", which was published by the government in July 2012, and set out the government's response to the recommendations of the Commission on Funding of Care and Support.

In this document, the government reveals that: 1) it accepts as the basis for reform the principle put forward by the Commission of financial protection through capped costs and an extended means test; 2) it will not make a decision on the 'capped cost' model until the next Spending Review (expected in late 2013); 3) it wants to explore alternative ways of applying this principle in practice beside the 'capped cost' model recommended by the Commission - effectively de-linking the Commission's model from the underlying principle.

Despite the extra cost presented by the 'capped cost' model being very small in terms of public spending, against a negative fiscal outlook and challenging demographic trends, the government is effectively stating that in order for the 'capped cost' model to be implemented, it would have to be cost-neutral for the Treasury and not interfere with the government's deficit reduction strategy. However, the government fails to set out – or even acknowledge - any of the options for paying for the 'capped cost' model that have been identified by commentators and stakeholders, and does not seek to use "Caring for our future: progress report on funding reform" to inform a wider debate on this issue.

In evaluating the 'capped cost' model, the government identifies a range of benefits of the 'capped cost' model, associated with: insurance and peace of mind; behavioural benefits; and, a market for financial services.

However, a striking feature of "Caring for our future: progress report on funding reform" is that the government uses this publication to clarify the fact that the 'capped cost' model would not cap all of a person's care costs, but only the amount of local authority support that individuals are excluded from owing to their wealth. But, the government does not provide any data on what self-funders would typically have to pay toward their care costs before the 'cap' and as 'top-ups' beyond it, and the absence of this information is a significant omission. In addition, the government also fails to provide any detailed information or projections on the size and value of the insurance market that it would expect to result from the implementation of the 'capped cost' model.

Nevertheless, in "Caring for our future: progress report on funding reform", the government says that it will take forward several recommendations of the Commission: introduction of a universal deferred payments scheme from April 2015; introduction of a national minimum eligibility threshold; implementation of reforms announced in the accompanying White Paper on social care, including legislating to enable portability of assessments.

It is important to note, however, that the Commission's recommendation of a universal deferred payment scheme was made in the context of the 'capped cost' model, and in implementing such a scheme, the government should not be seen as implementing the Commission's recommendations. In addition, although setting a minimum eligibility threshold for all councils, local authority needs assessments and allocations of support will still take account of the availability of informal care, local budgeting decisions and local unit care costs. As such, the system will inevitably remain characterised by a 'postcode lottery' and unpredictability.

Despite the disappointment of social care campaigners with the publication of "Caring for our future: progress report on funding reform", it does suggest several scenarios for the long-term care funding reform agenda going forward.

Full implementation of the 'capped cost' model at the next Spending Review is still possible and the period up to the Spending Review will provide an opportunity for social care campaigners to shift public attitudes to potential tax rises and spending cuts that could be used to fund the 'capped cost' model in a cost-neutral way, such as National Insurance Contributions for older workers.

An alternative approach would be to reduce the cost – and generosity – of the 'capped cost' model, although this would also affect the perceived benefits of the model.

In addition, a key announcement in "Caring for our future: progress report on funding reform" was the government's interest in a 'voluntary' version of the 'capped cost' model. If a voluntary, opt-in 'capped cost' scheme did enable individuals to be better protected from the catastrophic costs of care – protection that the private sector finds all but impossible to provide - this would enable the government to argue that it had implemented the core principle put forward by the Commission.

A voluntary 'opt-in' or 'opt-out' 'capped cost' model, in which individuals paid an up-front 'premium' for protection from catastrophic costs could not be run through local authorities because of the nature of local authority needs assessments, and the uncertainty of support that results. Similarly, the private sector struggles to provide

protection from catastrophic care costs, which was the central observation of the Commission.

However, a National Care Fund model, of the type previously explored by the Strategic Society Centre - with all risk held by the private sector[1] - could be used to offer individuals greater protection from catastrophic costs. As well as payments from income, and lump-sum premiums paid after death or when people are still alive, the government could explore whether individuals could pay the premium for a National Care Fund by opting out of certain universal pensioner benefits. Importantly, participation in a 'capped cost' National Care Fund could move from voluntary to mandatory over time: the fact that the model would not be compulsory to begin with would not prevent it from becoming so.

Ultimately, the fundamental truth of long-term care funding in England – that older people have sufficient wealth to ensure a well-funded, fair system of care funding – remains. This was implicitly recognised by the government in its recognition of the principle that those who benefit from reform should pay for it, and by the government floating the idea of a voluntary 'capped cost' model in which individuals could choose to use their wealth to obtain protection from catastrophic costs. The government is effectively recognising that reform can proceed in a way that does not disrupt the government's deficit reduction strategy.

As such, "Caring for our future: progress report on funding reform" showed that: 1) the government remains afraid of the 'political cost' of tax rises or spending cuts elsewhere required to reform care funding in a cost-neutral way; 2) the Treasury is extremely wary of ceding control of public spending decisions from the Spending Review process.

However, increasing public spending on care and support on top of the existing baseline system, and making progress toward a 'capped cost' funding system could still occur in a number of ways: public acceptance of the difficult tax and spending decisions required to make the 'capped cost' model cost-neutral for the Treasury; the implementation of a low-cost 'capped cost' model; the creation of a voluntary 'capped cost' National Care Fund, that may become mandatory over time.

1. Introduction: How did we get here?

This discussion paper provides analysis of "Caring for our future: progress report on care funding"...

On July 11th 2012, the Coalition Government published "Caring for our future: progress report on funding reform".[2]

Published alongside a White Paper on reform of social care provision and regulation, this 'progress report' set out the government's current position on long-term care funding in England, and specifically, provided the government's response to the recommendations of the Commission on Funding of Care and Support, chaired by Andrew Dilnot, which was published on July 4th, 2011.[3]

The Commission on Funding of are and Support ("the Commission") was launched in 2010, following the Coalition Government's commitment to:[4]

> "establish a commission on long-term care, to report within a year. The commission will consider a range of ideas, including both a voluntary insurance scheme to protect the assets of those who go into residential care, and a partnership scheme as proposed by Derek Wanless."

The government asked the Commission to make recommendations on:

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

This discussion paper provides analysis of "Caring for our future: progress report on funding reform". The paper seeks to:

- Set out the context for the 'progress report' on care funding reform by the government and the recommendations of the Commission one year ago;
- Explore the arguments put forward by the government for not making a decision on reform of care funding now;
- Review those measures which the government is committing to undertake before the next general election;
- Explore why the government is seeking to delink the principles put forward by the Commission from the model it proposed;
- Analyse the government's idea of a voluntary, opt-in version of the Commission's 'capped cost' model.

The paper concludes by setting out how progress can now be achieved in long-term care funding reform in England, in the wake of "Caring for our future: progress report on funding reform."

Key points:

- This discussion paper provides analysis of "Caring for our future: progress report on funding reform", which was published by the government in July 2012.

2. What is the Government's response to the Commission on Funding of Care and Support?

What did the Commission on Funding of Care and Support propose?...

What are the problems with England's long-term care funding system?

The Commission put forward the 'capped cost' model as a response to the specific 'brief' it was given, and the problems found in the long-term care funding system in England. These problems can be briefly summarised as:

- 'Postcode Lottery' – council support to individuals varies considerably across the country, and is unpredictable;
- Inadequate levels of support –it is widely felt that levels of support from councils for people with care needs are inadequate, and are declining as councils tighten eligibility criteria;
- Over-burdened family carers – many carers provide 'round the clock' care, often with severe consequences for their own well-being, health, income and employment prospects;
- Catastrophic costs – those paying for care privately 'out-of-pocket' can accumulate care bills totalling many tens of thousands of pounds, wiping out savings and assets accumulated over a lifetime;
- Rising demand – demographic change will see demand for public support grow substantially in coming decades, posing a significant public spending challenge. Just to maintain 2010 baseline spending on care and support at consistent levels, the proportion of GDP spent on care and support by the state will have to increase from 1.16% in 2010/11 to 1.39% in 2025/26.[5]

What did the Commission on Funding of Care and Support propose?

After a year of analysis and consultation, the Commission published its recommendations in July 2011.

The proposals in "Fairer Care Funding" were built around a central observation: individuals cannot obtain protection from very high care costs from the private sector, so it is the responsibility of the state to provide protection in this regard.

Applying this principle, the Commission proposed the 'capped cost' model, which built on the core components of the existing local authority social care system, in particular, needs-assessments and means-assessments.

The 'capped cost' model has two main elements:

- A £35,000 'cap on costs' – a cap on the financial value of council support that individuals are excluded from owing to their wealth. If individuals have qualifying care needs, but are above the means test threshold, their council will record how much they would have received, and 'meter' these amounts until they reach £35,000, beyond which a person will be entitled to support on a 'means blind' basis;
- Raised means test – the 'Upper Capital Limit' used by councils in means testing support for the costs of residential care should be raised from £23,250 to £100,000. Individuals with assessable wealth between £14,250 and £100,000 should be charged for support via the existing local authority 'tariff income' framework.

In addition to these core recommendations, the Commission made various supporting recommendations, including:

- General living costs - people in residential care should be expected to make a standardised contribution toward their living costs, with an amount between £7,000 to £10,000 each year considered appropriate;
- Eligibility - the eligibility criteria for service entitlement should be standardised on a national basis to improve consistency;

- Portability – individuals should be able to receive support from their council to carry their assessed level of need ('Moderate', 'Substantial', etc.) to a new local authority, before they are reassessed;
- Deferred payments – all individuals going into residential care should have access to council deferred payment schemes;
- Young adults – there should be free state support for care costs to young disabled adults;
- Disability benefits – the Attendance Allowance and social care systems should be better aligned;
- Assessments – the government should develop a more objective eligibility and assessment framework;
- Information – there should be a new information and advice strategy to help when care needs arise;
- Carers – there should improved assessments of carers and their needs;
- Integration – the government should review the scope for improving the integration of health and social care.

What is the government's response to the Commission's recommendations?

In "Caring for our future: progress report on funding reform", the government revealed that it has accepted the principle of the Commission's proposals as the right basis for any reform of care funding in England, which it describes as: financial protection through capped costs and an extended means test.

However, citing the structural deficit in the public finances, the government stated that it could not commit to introducing care funding reform based on the Commission's proposals at this stage. The government stated a final decision would be taken in the next Spending Review (which commentators expect in late 2013), and during the interim, the government would explore with stakeholders the best way of implementing a reform based on the principles put forward by the Commission.

However, the government did announce that it would take forward some recommendations of the Commission immediately, and would:

- Introduce universal deferred payments from April 2015;
- Introduce a national minimum eligibility threshold;
- Undertake reforms announced in the 2012 White Paper on social care, including legislating to enable portability of assessments.

So is the government committed to both the 'capped cost' model and the principles underpinning it?

No. An important feature of "Caring for our future: progress report on funding reform" is that the government sought to delink the principles put forward by the Commission from the 'capped cost' model it recommended.

In effect, the government is suggesting that there may be alternative ways for the government to realise the principles set forth by the Commission, besides the 'capped cost' model. In particular, the government poses the idea of a 'voluntary capped cost model', and this is explored more in subsequent chapters.

Why is the decision on care funding reform being delayed to the Spending Review?

At the time of a severe squeeze on the public finances, as well as unknowable uncertainties affecting future economic growth arising from the Eurozone debt crisis, HM Treasury will clearly be concerned with maintaining discipline around the process for making public spending decisions. As such, the government has said that any future decision on care funding reform can only take place in the context of a Spending Review, rather than outside this process.

However, it is worth noting that faced with significant political pressure, the government does make exceptions to the formal Spending Review process, most recently in relation to tax on fuel and bin collections.

Is the government right to blame the structural deficit for putting off reform?

"Caring for our future: progress report on funding reform" coincides with both an immediate crisis of public spending in the UK and negative long-term fiscal trends.

In its 2012 review of the government's finances and public spending, the Office for Budget Responsibility (OBR) observes that to return public sector net debt to around 40% of GDP – the level before the 2007 financial crisis – the government will need to need to implement a permanent tax increase or spending cut of 1.1 per cent of GDP - £17 billion in today's terms - by 2017-18.[6]

While the level of public sector debt as a proportion of GDP is a matter of political discretion, this does mean that boosting public spending on social care would make it harder to eliminate the structural deficit. By citing the structural deficit as a reason for not proceeding with reform, the government is effectively saying that eliminating the structural deficit is a more important political and policy priority than reform of care funding.

In addition, long-term fiscal trends are negative, owing to population ageing. In its July 2012 review, the OBR projects that public spending will increase from 35.6% of GDP to 40.8% of GDP by 2061-62, an increase of 5.2 per cent of GDP or £80 billion in today's terms.[7] The OBR observes that the main drivers of this change are age-related spending: health, the State Pension and social care. In particular, the OBR projects that social care costs will rise from 1.1% of GDP in 2016-17 to 2 per cent of GDP in 2061-62. This is the cost of simply maintaining the current system, rather than the extra cost associated with reforming it.

As such, the government already confronts a growing 'unfunded liability' just to maintain the existing social care funding system in England. In this context, increasing the generosity of the social care funding system – as the Commission recommended – may appear unaffordable.

So the government is simply not able to afford of reform care funding?

No. Several comments should be made. First, whether or not anything is 'affordable' in public spending is ultimately a political decision, driven by political priorities.

Second, the cost of the current social care system – and the extra cost of reforming it – are extremely small considered in the wider context of public spending, particularly when set against spending items such as the NHS.

Third, the government does have options for extra 'revenue raising' (taxation) and reprioritising (transferring) spending from other areas. A notable feature of "Caring for our future: progress report on funding reform" is that it contains no analysis whatsoever of what these options are. This omission is especially striking in the context of a number of recent reviews of these options by the Strategic Society Centre,[8] Institute for Fiscal Studies[9] and the Nuffield Trust.[10]

However – crucially – deploying some of these funding options does mean that the recommendations of the Commission, both now and in the future, could be implemented in a cost-neutral way, that would not disrupt the government's deficit reduction strategy. Indeed, by acknowledging the principle put forward by

commentators on care funding reform that those who benefit from reform should be the ones to pay for it, the government is implicitly acknowledging that there are potentially cost-neutral ways of funding the 'capped cost' model.

As such, the decision by the government not to commit to any reform results from a fear of political backlash from measures – tax rises, spending cuts elsewhere, etc. - that would allow care funding reform to proceed in a cost-neutral way, rather than because of the structural deficit.

Why hasn't the government examined potential sources of funding to pay for a reformed care system?

In large part, this may simply be because the government is afraid of becoming unpopular by floating such difficult choices with voters.

However, this omission is also likely to be because - in the context of an unprecedented fiscal crisis - the government wishes to have total freedom and control over public spending decisions at the time of the next Spending Review, rather than implicitly or explicitly linking potential tax rises or spending reprioritisation to reform of care funding. In this sense, any political and stakeholder consensus on how the 'capped cost' model should be paid for through public spending would threaten the primacy of the Spending Review process.

So, for example, while some commentators have suggested that some public spending on Winter Fuel Allowance for older people could be redirected to social care, HM Treasury may be keen instead for such a transfer to be directed at deficit reduction. Whether to allocate potential revenue from reprioritising public spending in this way is likely to be a key political and policy debate in coming years.

However, some commentators may nevertheless argue that there remains a fundamental intellectual dishonesty associated with the government not giving the public the opportunity to debate potential funding sources, in particular, potential new taxes that would be very unlikely to ever be used for deficit reduction, but which could be linked to funding a reformed care system. In this context, some commentators have pointed out that the older generation collectively possess billions of pounds of untaxed housing wealth, which could be directed into the care funding system in a variety of ways.

What is the government's attitude to the Commission's 'capped cost' model?

In "Caring for our future: progress report on funding reform", the government identifies a range of benefits of the 'capped cost' model:

- Benefits of insurance and peace of mind – i.e. reduced incidence of 'catastrophic costs' and the peace of mind this will bring to the population;
- Behavioural benefits – these are said to include:
  - Reduced unmet need and increased private preventative spending – with a 'cap', individuals may engage in less precautionary saving and spend more on their care, and preventative interventions.
  - Better planning and preparing – a 'cap' may give people greater certainty, better enabling them to plan ahead.
  - Reduced gaming of the system – by 'capping' how much individuals had to contribute toward their care, individuals would have less incentive to 'hide' their assets when undergoing a local authority means assessment.
- A market for financial services – the government reports that stakeholders in the financial industry as saying that new markets for financial products could emerge in response to the cap.

The government wishes to clarify that the 'capped cost' model would not cap all of a person's care costs...

However, a striking feature of "Caring for our future: progress report on funding reform" is that the government uses this publication to clarify at length the fact that the 'capped cost' model would not cap all of a person's care costs.

Why does the 'capped cost' model not cap all care costs?

The government explains how the 'capped cost' model does not cap all care costs as follows:

> "Progress towards the cap, and payments after the cap, would be calculated at the rate that the local authority would pay to meet each care user's needs. Some care users may buy more expensive services, but these extra costs would not be covered by the cap. Many self-funders currently pay more in care home fees than local authority-supported residents, so it would be important to ensure complete clarity about the level of support that they would be entitled to so that they can plan accordingly – for example by saving or buying an appropriate financial product to cover the additional costs."[11]

Although the government could in theory cap all care costs, this would not be feasible in practice given the very expensive care services purchased by high-income groups.

Recognising this constraint, the 'capped cost' model put forward by the Commission would only pay individuals the benchmark amounts that councils pay, rather than the higher costs that the vast majority of self-funders confront, ensuring that even having reached a cap, individuals would have to carry on topping up the support from their council.

More widely, this limitation of the 'capped cost' model is mirrored in alternative funding models. For example, 'free personal care' would not in fact see individuals receiving all their care for free; those in residential care who pay more than the benchmark amount funded by councils – the vast majority of self-funders - would continue to pay significant out-of-pocket payments, as is the case under 'free personal care' in Scotland.

Why is the government highlighting that the 'capped cost' model does not cap all costs?

The government may be underlining the fact that the 'capped cost' model does not cap all care costs in the face of what some commentators have described as a 'perception gap' that has opened up since the publication of the Commission's final report, and the number of stakeholders who believe that the 'capped cost' model would in fact cap all costs.

If the 'capped cost' model does not cap all care costs, what would individuals have left to pay?

As the government acknowledges, the 'capped cost' model would see many individuals continuing to make out-of-pocket payments toward care even after they had reached the £35,000 'cap'. It is also worth noting that such individuals would also have spent more than £35,000 on care before they reached the cap.

Given the 'capped cost' model would only ever see councils paying their benchmark fees for care – particularly residential care – it is clearly very important to understand what average care users would have paid before they reached the £35,000 'cap', and what they would have to go on paying after the 'cap'. It is striking that "Caring for our future: progress report on funding reform" does not address this issue.

More generally, there is a notable absence of data regarding the difference in residential care fees paid by 'self-funders'.

According to the NHS Information Centre, the average amount paid by councils in England for residential care of older people by external providers in 2010-11 was £470.[12] However, the average weekly fee charged by for-profit homes in 2010 for residential care (excluding

The government needs to provide information on what 'self-funders' would have to pay for care before and after they reach a 'cap'...

nursing care) to both council-funded and 'self-payer' residents was around £500. Since this £500 figure is the average fee paid by both council and self-funders in residential care – of whom there are 170,000 and 125,000 respectively - the difference paid by self-funders to what councils pay is likely to be more than £30 per week.

A key priority for the government going forward will therefore have to be setting out precisely:

- What is the average difference in weekly fees paid by councils and self-funders for both domiciliary and residential care;
- How much self-funders in residential care would typically have spent in excess of £35,000 before they reached the £35,000 cap;
- Setting out how much self-funders in residential care would on average carry on having to pay each week beyond the £35,000 cap, in excess of general living costs.

Not only would such information provide greater clarity regarding the extent to which the 'capped cost' model would cap costs and provide protection from catastrophic care costs, it would provide greater understanding of the limitations of other funding models, such as 'free personal care'.

If the 'capped cost' model does not cap all care costs, does this affect the public policy benefits of the model?

As "Caring for our future: progress report on funding reform" observes, the 'capped cost' model does not cap all care costs.

However, it is unclear from this report whether the government's evaluation of the benefits of the model - benefits of insurance and peace of mind, behavioural benefits, a market for financial services – have been undertaken on the basis of assuming that the 'capped cost' model capped all care costs, or only that some costs would be covered.

For example, if individuals still expected to pay substantial out-of-pocket payments for residential care even after they had reached the £35,000 'cap', would this affect the peace of mind benefits of the model, or behavioural effects such as individuals spending more on prevention?

Exploring these issues is likely to be an imperative as the government the government consults with stakeholders around "Caring for our future: progress report on funding reform". Indeed, it is striking that the benefits of the 'capped cost' model listed by the government are drawn from theoretical assumptions in economics, rather than from empirical evidence, for example, resulting from piloting.

Would the 'capped cost' model result in a market for insurance?

A very notable feature of the government's evaluation of the 'capped cost' model in "Caring for our future: progress report on funding reform" is that it contains no projections whatsoever of how many individuals would in future be likely to purchase pre-funded care insurance following the implementation of the 'capped cost' model, what revenue would be derived for the care system from the sale of these insurance policies, and when such revenue would come on stream.

There is a clearly an urgent need for such modelling to take place. Previous analysis by the Strategic Society Centre has explored how – given the local authority social care system is built around 'carer-sighted' needs assessments, and support is subject to local discretion - it would be actuarially impossible for any private insurance company to forecast when any individuals would reach the £35,000 'cap' of the 'capped cost' model. This would likely have significant

The government has failed to provide any detail on the size or value of a pre-funded care insurance market it would expect to develop in response to the 'capped cost' model...

consequences for both the design of products and consumer experience.[13]

Key points:

- In "Caring for our future: progress report on funding reform", the government reveals that: 1) it accepts the principle of financial protection through capped costs and an extended means test; 2) it will not make a decision on the 'capped cost' model until the next Spending Review; 3) it wants to explore if there are alternative ways of applying this principle in practice beside the 'capped cost' model recommended by the Commission.
- The government is effectively stating that in order for it to be implemented, the 'capped cost' model would have to be cost-neutral for the Treasury, and not interfere with the government's deficit reduction strategy.
- The government has set out that the 'capped cost' model would not cap all of a person's care costs. But, the government does not specify provide any data on what self-funders would typically have to pay toward their care costs before the 'cap' and as top-ups beyond it, and the absence of this information is a significant omission.
- The government has also failed to provide any detailed information or projections on the size and value of the insurance market that it would expect to result from the implementation of the 'capped cost' model.

3. What is the Government doing now to reform funding of care and support?

The government is going to introduce a universal deferred payment scheme for care fees from 2015...

What is the government doing now to reform funding for care and support?

In "Caring for our future: progress report on funding reform", the government said that it would take forward several recommendations of the Commission immediately, and would:

- Introduce universal deferred payments from April 2015;
- Introduce a national minimum eligibility threshold;
- Undertake reforms announced in the White Paper on social care, including legislating to enable portability of assessments.

What does the universal deferred payments scheme mean in practice?

At present, some councils choose to offer deferred payment schemes to individuals going into residential care, whereby they are lent money by the council to pay for their residential care fees until their home is sold, often after death. The scheme prevents disruptions resulting from individuals not being able to sell their home, and can prevent the emotional distress for people in residential care that arises from the sale of their home.

However, the proposal for a universal deferred payment scheme put forward by the Commission was intrinsically linked to the 'cap' on costs. As such, although the implementation of this proposal is likely to increase the choices available to families – and reduce the emotional distress of older people forced into selling a home – it should not necessarily be seen as implementation of the Commission's recommendations.

Are there differences to existing deferred payment schemes and what the government is proposing?

Yes. At present, councils do not typically charge interest for loans made under deferred payment schemes, which effectively represents a subsidy by councils to those in residential care. Like the Commission, the government is proposing that universal deferred payment schemes should be cost-neutral to councils through interest being charged on the loans.

Nevertheless, the charging of interest, even if this is below commercial rates of interest, will change the nature of the scheme for families and the ultimate costs they have to pay.

The government states that it will finalise at a later date how universal access to deferred payment schemes will operate. In practice, it may be unfeasible for all councils to offer separate lending schemes, and the government may settle on a more national model, akin to the Student Loan Company.

Instead of a universal deferred payment scheme, could the government not simply rely on the private sector equity release market?

Deferred payment schemes are effectively a state-backed equivalent of private sector equity release products, and the decision by the government to ensure universal access to these schemes may have a negative effect on the nascent equity release market in social care.

However, there are various reasons that the government may prefer to prioritise a state-backed scheme for lending individuals the value of fees for care, rather than relying on the private sector to give people this option:

Because of the nature of the local authority care system, a minimum eligibility threshold will still result in local variations in support...

- Costs to individuals – a state-backed scheme will be cheaper for individuals and families, and enable the government to monitor and shoulder some of the interest-rate risk charges if interest rates increase substantially in future, so as to avoid people in care confronting high interest charges.
- Take up and transaction costs – a state-backed universal deferred payment scheme may enable the government to ensure participation is not reduced by some of the factors affecting private sector equity release products, such as consumer distrust of providers, the need to visit a financial adviser, etc.
- Security of provision – as a type of mortgage, private sector equity release products ultimately rely on the functioning of international capital markets, and were therefore adversely affected by the 2008 'credit crunch'. At a time of ongoing volatility and instability in global capital markets, the government may prefer to ensure security and consistency of provision to those in residential care – both in terms of availability and interest costs – given the acute dependency that individuals have on their care fees being paid.

What does the government mean by a national eligibility threshold for social care?

At present, councils undertaking needs assessments apply criteria called 'Fair Access to Care Services' (FACS). This is a risk-based assessment of need for support from the council, and allocates individuals to one of four categories: Low; Moderate; Substantial, and Critical.

The Commission argued that all councils should set their eligibility thresholds at no higher than Substantial. By accepting this recommendation, what this means in practice is that the small number of local authorities in England who have Critical as their eligibility threshold will have to lower it to Substantial.

So now there is a definite minimum level of care that individuals will receive?

No. Although individuals will now know that if they are assessed as having Substantial needs, they will definitely be entitled to some support from their council, the level and type of support will still be up to the discretion of councils, and will depend on council budgeting decisions for that year, as well as the unit costs of different types of care for individuals with different types of need.

As such, there will still be a significant element of unpredictability and variability in what individuals across the country receive, even if all individuals assessed by their council as having Substantial needs will definitely receive something.

Key points:

- The government is going to: introduce universal deferred payments from April 2015; introduce a national minimum eligibility threshold; undertake reforms announced in the White Paper on social care, including legislating to enable portability of assessments.
- However, the Commission's recommendation of a universal deferred payment scheme was made in the context of the 'capped cost', and in taking forward this recommendation, the government should not be seen as implementing the Commission's recommendations.
- In addition, although setting a minimum eligibility threshold for all councils, local authority needs assessments and allocations of support will still take account of the availability of informal care, local budgeting decisions and local unit care costs. As such, the system will inevitably remain characterised by a 'postcode lottery' and unpredictability.

4. Making Progress: What are the options?

The government may still decide to implement the 'capped cost' model in full at the next Spending Review...

With the government deferring a decision on care funding reform until the Spending Review, what are the options for the care reform agenda going forward?

Various scenarios can be conceived:

- Full implementation of the 'capped cost' model at the next Spending Review;
- 'Low-cost' or partial implementation of the 'capped cost' model;
- Implementation of a voluntary version of the 'capped cost' model, built around a National Care Fund;
- Other models of 'partnership' between individuals and the state for the cost of care.

This chapter explores these different scenarios in turn.

What is likely to happen at the next Spending Review?

The next Spending Review – expected in late 2013 – will see crucial decisions taken regarding the 'capped cost' model.

The period up to the next Spending Review will provide an opportunity for social care campaigners to lobby the government for increased spending on care. However, this will coincide with other, rival interest groups also lobbying the government for money.

Social care campaigners, particularly older people's groups, will also continue to confront a key strategic dilemma around potential sources of funding for the care system, such as trimming public spending on Winter Fuel Allowance or income tax rises for older people. Although campaigners could propose to the government that some of resource required for reforming the care funding system should be found in this way, this might have the result that such funding sources will indeed be accessed by the government, but used instead to fund deficit reduction, or the growing cost of simply maintaining the current system in face of demographic pressures. Indeed, the Treasury is likely to prefer to use potential funding sources for care to 'plug the gap' in the current system, rather than make the system more generous, even if reform might be the only way of making options – such as National Insurance Contributions from older workers – acceptable to the public.

Could the government implement a 'low-cost' version of the 'capped cost' model?

In order to reduce the financial challenge posed by the 'capped cost' model, the government could opt to introduce a lower-cost version involving:

- A 'cap' on costs set at £50,000, £100,000 or some other level;
- Raising the Upper Capital Limit for residential care to a level below the £100,000 figure proposed by the Commission, such as £70,000;
- Increasing the amount that individuals are expected to contribute under the 'capped cost' model to general living costs.

In "Caring for our future: progress report on funding reform", the government sets out the cost to public spending of making the 'capped cost' model less generous by changing these variables.

However, reducing the generosity of the 'capped cost' model would clearly also affect the perceived benefits of the model:

- Benefits of insurance and peace of mind;
- Behavioural benefits;
- A market for financial services.

For example, a 'cap' on costs of £100,000 would clearly bestow less peace of mind to the population than a 'cap' of £35,000.

The government wants to explore a voluntary, opt-in ‘capped cost’ model...

However, in the absence of any empirical evidence of the benefits of the ‘capped cost’ model in practice – most benefits listed by the government are drawn from theoretical assumptions in economics – it is impossible to do a conventional cost-benefit analysis to judge an optimal cost for the ‘capped cost’ model.

Could the government partially implement the ‘capped cost’ model in order to reduce costs?

Various commentators have observed that the increase in the Upper Capital Limit for residential care to £100,000 proposed by the Commission on Funding of Care and Support could be implemented independently of the ‘cap’ on costs, and would provide greater asset protection than at present. The Commission estimated that the cost of increasing the Upper Capital Limit in 2010 with a ‘cap’ in place would have been around £100 million. Without a ‘cap’, the cost would likely be somewhat higher.

Why has the government floated the idea of a ‘voluntary capped cost model’?

A key announcement in “Caring for our future: progress report on funding reform” was the government’s interest in a ‘voluntary’ version of the ‘capped cost’ model.

Although accepting the principles of the Commission’s recommendations as the right basis for any new funding model – financial protection through capped costs and an extended means test - the government has also accepted the principle that those who benefit from reform should be the ones to pay for it.

In fact, the Commission itself suggested that if the ‘capped cost’ model were funded through any new tax increase, then “it would make sense for this to be paid at least in part by those who are benefiting directly from the reforms.”[14]

Combined with the difficult fiscal context for reform, these principles have led the government to suggest that one option it would like to explore with stakeholders is whether reform could be based on a “voluntary or opt-in funding system, where people have a choice to pay a specified amount to receive financial protection from the state.”[15]

The government explains this approach as follows:

> “People could individually make the choice to be protected by the capped cost scheme – and only people that opt in would pay the cost.”[16]

As well as ‘opt-in’, the government makes clear that it would be interested in ‘opt-out’ approaches, based on some form of ‘auto-enrolment’.”

A voluntary approach to the social insurance that the ‘capped cost’ model was intended to provide clearly contradicts the objectives of the Commission ‘capped cost’ model.

However, if a voluntary scheme did enable individuals to be protected from the catastrophic costs of care – protection that the private sector finds all but impossible to provide - this would enable the government to argue that it had implemented the core principle put forward by the Commission.

In addition – crucially – a voluntary scheme would not have to remain voluntary forever, and could in fact become mandatory when the older population was accepting of the idea of making a new contribution for protection against care costs.

Would councils be able to implement a voluntary ‘capped cost’ model?

No. A voluntary ‘opt-in’ or ‘opt-out’ ‘capped cost’ model, in which individuals paid an up-front ‘premium’

A voluntary 'capped cost' model could not be run through local authorities, or by the private sector...

for protection from catastrophic costs, could not be run through local authorities.

Why? The key barrier is that local authority funding for a person's care costs is allocated via 'carer-sighted' needs assessments, in which support is proportional to the availability of informal (family) care. In addition, the value of support provided by councils to individuals is dependent upon individual council budgeting decisions (how much they choose to spend on social care that year), as well as the unit costs of different types of care and support in a given area.

In short, in exchange for a voluntary premium, individuals would have no idea what they would actually receive from their council under a voluntary 'capped cost' model, when they made a 'claim'.

Consider the following analogy: would individuals purchase car insurance if, when their car was stolen or damaged, whether or not they received a replacement car from their insurance company depended upon:

- Whether their insurance company thought that they really needed a car, and could rely instead on other forms of transport such as buses, or lifts from family members;
- How much the insurance company has decided to spend in total on reimbursing claimants on car insurance policies in that year;
- What value of car an insurance company thinks the person requires, given the cost of purchasing cars in the local area?

Faced with such a car insurance policy, no sensible consumer would voluntarily purchase such insurance. Similarly, no sensible individual would seek to voluntarily participate in a 'capped cost' scheme, in which the support provided in return for an opt-in premium was determined through local authority needs assessments.

Could the private sector insurance industry offer a voluntary 'capped cost' insurance product?

No. The central observation of the Commission was that insurance companies struggle to offer conventional pre-funded insurance against catastrophic care costs because of intractable actuarial difficulties, in particular:

- Uncertainty regarding how many people will experience different levels and types of disability (morbidity risk) in future;
- How long claimants on policies would go on living in future (longevity risk).

Indeed, the core foundation for the Commission's recommendations was recognition that the private sector cannot provide protection to the population from catastrophic care costs.

Could a state-sponsored insurance scheme – or National Care Fund – deliver a voluntary 'capped cost' model?

Yes. Various countries operate state-sponsored insurance schemes for social care costs. In debate on long-term care funding in England, the most prominent proposal for a state-sponsored insurance scheme was the proposal for a National Care Fund, first put forward by the current author in 2008,[17] and updated extensively in 2011.[18]

Ultimately, the National Care Fund model provided a framework for a state-sponsored insurance scheme for care costs in England, and multiple different iterations of the model have been developed by the current author. The key 'design decisions' for a National Care Fund would be:

- Value of premium and cover (what participants pay and receive when they claim);

However, a voluntary, state-sponsored ‘capped cost’ National Care Fund would be possible...

- Eligibility threshold – what level of disability an individual has to have in order to be able to claim;
- Payment options – payments could include a lump-sum at retirement age, contributions from income or a lump-sum after death;
- Basis of participation – this could be purely voluntary, auto-enrolment (soft-compulsion) or mandatory.

The model of a National Care Fund model could be adapted so as to give individuals the opportunity to obtain greater protection against catastrophic care costs.

How would a ‘capped cost’ National Care Fund work?

Individuals would pay an upfront premium to obtain ‘capped cost’ protection. At the point of a pre-defined level of disability – most likely measured using an Activity of Daily Living (ADL) score - the individual would make a claim on the Fund. At that point, the Fund would not make payments to the individual, but would effectively assume that individuals were covering their care costs themselves. However, at a pre-determined point in time after the initial successful claim – e.g. one year, the Fund would then begin to make payments, thereby providing greater protection from catastrophic care costs. Alternatively, instead of deferring support on the basis of time, an ‘accumulated disability’ version would see individuals given support once they had experienced an accumulation of disability measured by number of Activity of Daily Living failures per month.

The cost of the premium for a ‘capped cost’ National Care Fund would depend on the value of the pay-out it provided, and how long after a person first reached the qualifying level of disability the person would then be entitled to payments.

The scheme would not be able to undertake to fund all of a person’s care costs, for similar reasons that the ‘capped cost’ model cannot also do this, i.e. unpredictability of what ‘unit care costs’ will be in future and what individuals will choose to spend on care.

Would the Treasury have to underwrite a ‘capped cost’ National Care Fund?

No. Analysis by the Strategic Society Centre in 2011 showed how a National Care Fund could be run entirely via the private sector, using the bulk purchase of point-of-need annuities.[19] A ‘capped cost’ National Care Fund could operate in the same way, but instead involving the bulk purchase of ‘deferred-need annuities’.

If a state-sponsored insurance scheme is set up to provide protection from ‘catastrophic costs’, would it not make sense to offer individuals the option of support from the point of qualifying need?

Yes. If the government were to invest in the creation of a state-sponsored insurance scheme to offer protection to the population from catastrophic care costs, it would be perverse to not also offer – in return for a more expensive premium – the option of protection (cash payments) from the point that individuals make a successful claim on the Fund, rather than from a given moment after this point.

Are there other ways in which individuals could pay their contribution to a ‘capped cost’ National Care Fund without having to sign over a premium?

In recent debate, various commentators have explored how there may be scope to trim expenditure on universal benefits for older people – notably Winter Fuel Allowance and free bus passes – to transfer resources to the social care system.

Such a scheme could move from voluntary to compulsion over time...

In the context of a voluntary, opt-in 'capped cost' insurance scheme, an alternative mechanism would be to give individuals the choice of opting out of some of their universal pensioner benefits in lieu of the premium for a 'capped cost' National Care Fund. In effect, individuals would be given a choice between retaining full entitlement to their universal pensioner benefits, or opting instead for 'capped cost' protection from care costs.

Would it not be better to have a compulsory 'capped cost' National Care Fund rather than a voluntary one?

As described, participation in a 'capped cost' National Care Fund could be voluntary, compulsory, or based on some form of soft-compulsion.

However, as the Strategic Society Centre has previously explored,[20] creating a voluntary National Care Fund would be no barrier to making participation mandatory. As such, it would be illogical to object to a voluntary 'capped cost' model on the basis that it is not mandatory.

So a voluntary 'capped cost' National Care Fund does not have to remain the same forever?

No. Over the course of a decade, a National Care Fund could offer protection from the point of quality disability, not just 'catastrophic costs'. In addition, participation could move from opt-in, to opt-out to being compulsory over the same period.

Are other models for a new partnership between individuals and the state in sharing the costs of care?

Yes. As the Strategic Society Centre has explored,[21] there are various other 'partnership' models that could be implemented alongside, or as an alternative to, the Commission's 'capped cost' model.

Key points:

- Various scenarios can be conceived for the long-term care funding reform agenda going forward: full implementation of the 'capped cost' model at the next Spending Review; implementation of 'low-cost' or partial implementation of the 'capped cost' model; a voluntary version of the 'capped cost' model, built around a National Care Fund; other models of 'partnership' between individuals and the state for the cost of care.
- The period up to the next Spending Review will provide an opportunity for social care campaigner to shift public attitudes to potential tax rises and spending cuts that could be used to fund the 'capped cost' model in a cost neutral way, such as National Insurance Contributions for older workers.
- A voluntary 'opt-in' or 'opt-out' 'capped cost' model, in which individuals paid an up-front 'premium' for protection from catastrophic costs, could not be run through local authorities because of the nature of local authority needs assessments. Similarly, the private sector struggles to provide protection from catastrophic care costs, which was the central observation of the Commission.
- However, a National Care Fund model, of the type previously explored by the Strategic Society Centre, with all risk held by the private sector, could be used to offer individuals greater protection from catastrophic costs.
- Importantly, participation in a 'capped cost' National Care Fund could move from voluntary to mandatory over time, so the fact that the model is not compulsory to begin with would not prevent it becoming so.

5. Conclusion: How will progress now be achieved?

The long-term care funding reform agenda is not at an end, and could proceed on a cost-neutral basis for the Treasury...

Huge disappointment greeted "Caring for our future: progress report on funding reform". Is the long-term care funding reform agenda at an end?

No. The fundamental truth of long-term care funding in England – that older people have sufficient wealth to ensure a well-funded, fair system of care funding – remains, and that as such, it is possible for care funding reform to proceed in a way that is cost-neutral to the Treasury and the deficit reduction strategy.

This was implicitly acknowledged by the government in its recognition of the principle that those who benefit from reform should pay for it, and by the government floating the idea of a 'voluntary capped cost' model in which individuals could choose to use their wealth to obtain protection from catastrophic costs.

As such, "Caring for our future: progress report on funding reform" showed that: 1) the government remains afraid of the 'political cost' of tax rises or spending cuts elsewhere required to reform care funding in a cost neutral way; 2) the Treasury is extremely wary of ceding control of public spending decisions from the Spending Review process.

What would be required for the 'capped cost' model to be implemented at the time of the next Spending Review?

For this to happen, the government would have to be able to implement the 'capped cost' model – and close the 'funding gap in current care spending – in a cost-neutral way that does not affect deficit reduction, and with minimal 'political costs'.

As such, social care campaigners do have an opportunity to use the period up to the next Spending Review to shift public attitudes in relation to potential funding sources, such as changes to inheritance tax, capital gains tax, National Insurance Contributions for older workers, etc.

If the public were to become accepting of such changes between now and the next Spending Review, the government may have no trouble in implementing these measures in order to fund reform of care funding, and implement the 'capped cost' model. Cross-party consensus on such changes to tax and spending would also likely increase the probability of them being implemented.

So social care campaigners should now begin lobbying the public and newspapers?

Such activity would definitely increase the probability of the government deciding to implement the 'capped cost' model at the time of the next Spending Review.

However, it is important to underscore the associated risk: that any loosening of public attitudes – for example, toward entitlement to subsidised bus services for pensioners – would see the government use this expenditure to meet its objectives around eliminating the structural deficit, or to simply maintain the growing cost of the current baseline system.

Is progress more likely if campaigners and the government back a 'low-cost' version of the Commission's 'capped cost' model?

Lowering the cost of the 'capped cost' model will reduce the size of the funding challenge associated with implementing it, and therefore increase its chances of being implemented.

However, as the government and others have noted, lowering the cost will mean reducing the asset protection afforded to the population, and thereby the benefits of the model to the population.

Given the lack of information from the government regarding how much individuals would have to pay as 'top-ups' under the 'capped cost' model, before and after reaching the 'cap', and in the absence of any

Reform will be more likely in the context of public acceptance of the difficult tax and spending decisions required...

evidence from pilots, it is very difficult to estimate how far the budget associated with the 'capped cost' model could be reduced without fundamentally undermining the rationale of the model.

Can progress be achieved via a voluntary 'capped cost' National Care Fund?

Yes. A voluntary 'capped cost' National Care Fund could be made mandatory at any time, and it would be illogical to reject such a scheme because it was voluntary at the time it was implemented.

So, how will progress in long-term care funding in England now be achieved?

Baseline public spending on care and support will be addressed at the next Spending Review.

However, improving spending on care and support on top of this baseline and making progress toward a fairer system can occur in several ways:

- Public acceptance of the difficult tax and spending decisions required to make the 'capped cost' model cost-neutral for the Treasury;
- The implementation of a low-cost 'capped cost' model;
- The creation of a voluntary 'capped cost' National Care Fund, that may become mandatory over time.

Key points:

- The fundamental truth of long-term care funding in England – that older people have sufficient wealth to ensure a well-funded, fair system of care funding – remains.
- Improving spending on care and support on top of the baseline system and making progress toward a fairer system can occur in several ways: Public acceptance of the difficult tax and spending decisions required to make the 'capped cost' model cost-neutral for the Treasury; the implementation of a low-cost 'capped cost' model; the creation of a voluntary 'capped cost' National Care Fund, that may become mandatory over time.

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The Strategic Society Centre
145-157 St John Street
London
EC1V 4PY

www.strategicsociety.org.uk
info@strategicsociety.org.uk

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