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The First Step? A response to the Commission on Funding of Care and Support

Executive Summary

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Executive Summary

The Commission's proposals are built around the 'limited liability principle': individuals should not be exposed to the risk of 'catastrophic' accumulated care costs; given the insurance industry cannot offer protection, the state must step in and provide it instead. In the Commission's 'capped cost' model, all individuals with eligible needs – proportional to receipt of informal care – would be allocated notional cash support, even if they are too wealthy to qualify for actual support. Once the accumulated notional support reaches £35,000, they would be reassessed on a 'means-blind' basis. For residential care, the means-test threshold would be raised to £100,000.

Because the 'capped cost' model only records how much individuals would receive from their council, many would likely opt to top-up their care even after they have reached the £35,000 cap, so out-of-pocket payments would continue. The Commission recommends that 'deferred payment schemes' should be made available to everyone through a new duty on councils, so most individuals would likely use income and housing wealth to fund their £35,000 liability. Beyond this, the £35,000 liability is, strictly speaking, uninsurable, so the 'capped cost' model is unlikely to boost take-up of long-term care insurance; estimates suggest 6% take-up among retirees. Disability-linked annuity sales might reach around 9000 per year.

The extra cost of the 'capped cost' model would be £1.7 billion now, rising to £3.6 billion in 2025. Given most of the extra spending would go to wealthier households, stakeholders may insist it is wealthier older households who shoulder the extra costs. The NHS, and freezing the value of some older people's benefits could be used to fund the model. However, just to stand still, public spending on adult care and disability will have to rise by £11.5 billion per year by 2025. Older people's property wealth remains the best potential source of untapped new finance to bring into the social care system.

The government should take forward those recommendations of the Commission that do not require new expense - scaling up deferred payment schemes, enabling portable needs assessments – and proceed with piloting key aspects of the 'capped cost' model. When policymakers have assessed deliverability, politicians can make a judgement about priorities, and which step the implementation of the 'capped cost' model should represent in the ongoing process of long-term care funding reform. While the Commission has set out a compelling proposal for eliminating some of the disastrous consequences of the current system for some families, politicians must not be distracted from the much bigger of issue of how to drive significant, new funding into the social care system to cope with rising demand.

Introduction

The Commission on Funding of Care and Support was asked to make recommendations on how to achieve an affordable and sustainable funding system for care and support, across both domiciliary and residential settings. The Terms of Reference of the Commission set clear boundaries for what the Commission should examine, and were also explicit in emphasising a 'partnership' between individuals and the state, and the importance of enabling individuals to *choose* to protect their assets, especially their home.

To advance the debate, this report seeks to provide: objective, impartial analysis of the recommendations of the Commission and their implications for families and care providers; supporting analysis of related policy issues that fell outside the Commission's scope, such as Attendance Allowance; and, exploration of key choices and options for the government as it prepares its response to "Fairer Care Funding".

The current system and its problems

The current long-term care funding system in England is built around local-authority assessments of need, which explicitly take account of informal care received in determining levels of council support. Those with more than £23,250 in 'assessable capital' – which frequently includes a person's home in assessments for residential care support – will receive nothing from their local authority.

The principal problems associated with the long-term care funding system in England are: underfunding in the face of rising demand; means-testing; the incidence of 'catastrophic costs'; over-burdened family carers; the 'postcode lottery in public support; and, complexity.

Is the 'limited liability principle' underpinning the Commission's proposals the right one?

At the core of the Commission's proposals is the 'limited liability principle', which argues that it is unfair to leave individuals exposed to the risk of 'catastrophic' accumulated care costs that occur when someone needs high levels of formal care for a long time; and, given the insurance industry cannot provide protection to the population against such costs, the state must step in and provide it instead.

Why can't the insurance industry provide cover against 'catastrophic costs'? The insurance industry confronts intractable problems in 'pricing' the risks associated with pre-funded long-term care insurance: the chances that someone will need care, and how long they will need it for. Because

individuals may need care far into the future, the data available to insurers to price this risk is inevitably inadequate, and insurers confront significant *uncertainty*.

Are the arguments for the limited liability principle therefore really about helping the insurance industry? Fundamentally, the principle of 'limited liability' is about the welfare state, and the state fulfilling those functions in people's lives that it can undertake far more easily than the insurance industry. It implicitly recognises the essential role of the state in mitigating some of the risks that the whole population confronts.

How can the limited liability principle be applied to care funding?

There are different ways in which the 'limited liability principle' can be applied to the long-term care funding system. Options include models that measure cost in terms of 'accumulated expenditure' and 'accumulated disability'. However, each approach has different trade-offs such as the effect on incentives to provide informal care, administrative costs, and fairness.

The Commission's model applies the limited liability principle through an 'accumulated need' model, in which need is measured proportional to receipt of informal care, in the same way local authorities currently assess need.

How does the Commission propose to cap the care costs of individuals?

Existing local authority needs-assessments and means-testing rules for care and support would still apply, in relation to both the £23,250 threshold and what constitutes 'assessable capital'. However, all individuals with eligible needs will be allocated a *notional* cash value of support, even if they do not qualify for an *actual* package of support, because of the means-test.

When the accumulated financial value of a person's *notional* support reaches £35,000, individuals will then be entitled to support on a 'means-blind' basis, and they will then receive *actual* support, regardless of whether they are still above the 'means-test' threshold. A more accurate name for the Commission's 'capped cost' model would therefore be a '*capped exclusion from means-tested support*' model.

A cap of £35,000 is judged by the Commission to balance value-for-money for the state with the realisation of the benefits of the model, such as 'peace of mind' among the population. For residential care, the Commission also proposes that the means-test threshold be raised from £23,250 to £100,000. However, the Commission argues that even with a raised level, the threshold remains too 'blunt', so it proposes that for those in residential care, 'tariff income' would

be calculated as under the current system on assets between £14,250 and £100,000.

The Commission also argues that since it is reasonable to expect individuals to plan for their *living costs* in retirement, individuals receiving state-funded residential care should, provided they can afford to, make a contribution to the cost of their residential care proportional to these *living costs*. The Commission recommends that retirees should make a contribution toward living costs in residential care of between £7,000 and £10,000.

For individuals below the age of 40, the Commission argues the £35,000 cap should be set at zero, but should then increase by £10,000 every ten years, until a person reaches 65.

Will the Commission's 'capped costs' model actually cap a person's spending on care? Not necessarily. The 'capped cost' model records how much individuals would receive from their local authority for domiciliary or residential care, if their assessed wealth did not exclude them from support. As such, *it is likely that many households would choose – or be compelled – to top-up their expenditure on care even after they have reached the £35,000 threshold.* As a result, for many individuals, their experience of the 'capped cost' model would likely be that it would not cap out-of-pocket expenditure on care and support, particularly in relation to residential care.

Is the Commission's 'capped costs' model regressive? In terms of capital protection, not much: the difference in capital protection afforded to most individuals varies by a range between 10-30%. At a system-level, the 'capped cost' model would still see 75% of public spending on care directed at the bottom three income quintiles of older people.

However, if the model is viewed in terms of *additional* public expenditure on care and support by income group, analysis by the Commission makes it clear that more of the additional spending would go to the top two income quintiles of older people than the bottom three.

How can individuals meet the £35,000 cost?

Ultimately, there are two ways that individuals could meet their £35,000 liability under the 'capped cost' model, in addition to simply paying out of income: spending down savings and the value of property wealth; engaging in risk-pooling (insurance).

In relation to property wealth, the Commission recommends that the existing 'deferred payment scheme' run by local authorities for those in residential care not receiving state support should be made

available to everyone through a Duty on councils. One effect of this may be to crowd out the commercial equity release market.

Will the 'capped cost' model result in a market for pre-funded long-term care insurance? Strictly speaking, a person's £35,000 liability is uninsurable since it is determined by factors (risks) that insurers cannot price for: the availability and receipt of informal care; and, council decisions on levels of support.

In the absence of the complementary pre-funded insurance products that take individuals up to the £35,000 threshold, insurers could offer a 'lump-sum' £35,000 payment insurance for individuals experiencing a defined level of disability, such as 3 Activity of Daily Living (ADL) failures. In such a situation, it would be left to individuals and families to manage their care expenditure in such a way they did not 'over-consume' care, and therefore find themselves running out of money before they reached the £35,000 cap.

How many people would be likely to take-out such lump-sum pre-funded long-term care insurance? Assuming a £10,000 premium, estimates using optimistic assumptions suggest around 6% of retirees - 45,000 per year – would purchase insurance. This would represent around £525 million of new revenue for the English social care system each year.

Does the 'capped cost' model encourage people to buy pre-funded insurance? It may in fact disincentivise individuals from purchasing insurance because the 'scariest' care-related risk they confront – catastrophic costs – is being shouldered by the state. Policymakers would also have to explore many issues regarding how pre-funded insurance would interact with aspects of the 'capped cost' model, for example, the mechanisms used to determine the annual increase in the £35,000 threshold.

So it is unlikely that the 'capped cost' would unleash a pre-funded insurance market, and the Commission itself notes: *"we do not think it is likely that there will be significant growth in specific, pre-funded long-term care insurance products."*

The Commission pinpoints 'disability-linked annuities' (DLAs) as being another way in which individuals could obtain protection against the £35,000 liability they would be left with.

However, as with pre-funded insurance, the way in which the 'capped cost' model calculates needs – on a carer-sighted basis – will make it impossible for a DLA to interlock with the £35,000 cap. So what would be the likely take-up of DLAs under the 'capped cost'

model? Multiple factors limit the size of the market. Only around half of working-age pension savers are saving into a 'defined-contribution' schemes that could be used to buy a DLA. Many also only have small pension pots at retirement. Most individuals purchasing annuities also seek to maximise their immediate income, so DLAs may not be popular, as they will provide a lower immediate income.

Rough estimates suggest annual sales of DLAs under the 'capped cost' model would be around 8,400 per year, bringing in just under £200 million of *new* funding into the social care system each year from around 2025 onwards.

In relation to immediate needs annuities (INAs) purchased at the point of entry into residential care, it is likely this market would grow under the 'capped cost' model, because a self-funder entering residential care would know how their notional package of support would accumulate, and with more generous support from councils for self-funders who pass the £35,000 threshold, more self-funders would be able to afford an INA.

A detailed piece of analysis into improved affordability of INAs under the 'capped cost would be required to assess changes in take-up. However, a benchmark level - assuming improved availability of financial advice – might see take-up increasing from the current 6% of self-funders in residential care to 20%.

How will individuals fund their £35,000 liability under the 'capped cost' model? Overall, although the model may create some space for use of financial products, and the INA market in particular may grow in light of improved affordability, it is likely many households would opt, or be compelled, to 'self-insure' through conventional savings products (e.g. ISAs) and drawing on the value of their home via the Deferred Payments Scheme.

Whether or not this would be problematic for policymakers would likely depend on how much individuals were having to top-up their care expenditure after reaching the £35,000 cap, because families deemed the level of council support available – across both domiciliary and residential settings – as inadequate.

How should the government fund the 'capped cost' model?

How could the government fund the 'capped cost' model? The key costs associated with implementing the model are: the cost of capping individual liability at £35,000; and the cost of raising the asset threshold for residential care to £100,000.

What extra costs will the model impose on the social care system? In 2010/2011 prices, the *extra* cost of the model would be £1.7 billion now, rising to £2.8 billion in 2020 and £3.6 billion in 2025. Considered as a percentage of GDP, this would represent 0.14% today rising to 0.22% in 2025.

However, the costs of the social care system in England will rise even under a 'no reform' scenario from £14.5 billion today to £22.8 billion by 2025. Over the same period, the cost of adult disability benefits will increase from £11.7 billion to £14.9 billion.

Implementing the 'capped cost' model would therefore require the Exchequer to find an extra £3.6 billion by 2025 to fund the 'capped cost' model on top of the £11.5 billion needed to maintain disability-related public expenditure on adults at equivalent levels as at present. The Commission notes that in order to fund the 'capped cost' model, the government could raise additional revenue through general taxation, reprioritise existing expenditure or introduce a specific new tax.

However, there are no immediately obvious sources of new taxes or transfers from other areas of spending available for funding the 'capped cost' model. The most likely sources would be the NHS, and freezing – but not cutting - the value of older people's benefits. Overall, the recommendations of the Commission do nothing to change the widely-made observation that older people's property wealth is the best potential source of untapped new finance to bring into the social care system, to meet both rising demand for today's entitlements, and new more generous entitlements such as those proposed by the Commission.

What does the Commission say about the 'postcode lottery'?

The only measure put forward by the Commission to address the 'postcode lottery' in support is portable need-assessments, such that individuals moving to a new local authority would be entitled to the same level of support until they are reassessed.

There are entirely logical reasons for the Commission to preserve the core role given to local discretion by the current system. However, the 'postcode lottery' in care and support will remain under the Commission's proposals, with associated problems around unpredictability, local variation and perceptions of unfairness.

What does the Commission say about Attendance Allowance?

The Commission supports the role of Attendance Allowance (AA) – the principal disability benefit for retirees - in addressing lower-level needs, and recognizes its

rationale, as a universal, non-means tested benefit.

Nevertheless, the Commission feels there may be more scope for joined-up assessments, as well as changing the name of AA to clarify its purpose. More widely, previous work by the Strategic Society Centre has explored the multiple options available for improving the integration and coordination of AA with social care including data-sharing, and formally positioning AA as an entry-point into the social care system. There is now an excellent opportunity to improve coordination and integration across disability benefits and social care.

What is the offer for informal carers?

The Commission's recommendations on supporting informal carers build on previous government Carers' Strategies and the recent recommendations of the Law Commission. Highlights include: carers being fully consulted about the support they need to ensure that the demands placed upon them are not too much; a new social care statute setting out a single and stand-alone duty to undertake carer's assessments, on the basis of which councils would have to decide whether to provide services to the carer based on a new an eligibility framework for carers' services.

Nevertheless, despite building their recommendations specifically around a 'carer-sighted' assessment of need, the Commission's proposals do not offer any significant advancement for informal carers on proposals that have been circulated previously. In addition, the 'capped cost' model will pose a dilemma for policymakers, as it may create resentment among families who save the state many thousands of pounds over a period of years through providing informal care, only to find that the person they care for is still liable for £35,000 of care costs when entering residential care.

What are the delivery issues for the 'capped cost' model?

The 'capped cost' model creates a number of challenging implementation issues that policymakers will have to address:

- Despite the incentives to seek assessment, there may be challenges in getting individuals assessed at the time they experience qualifying levels of need.
- Although the Commission proposes annual re-assessments, fluctuations in people's disability may require mechanisms to trigger extra reassessments.
- The Commission proposes a complete reform of the Fair Access to Care Services (FACS) framework.
- Policymakers will have to review local authority needs-assessment to ensure they up to the task required of them in the

'capped cost' model. For example, where wealthy individuals opt to purchase formal care rather than rely on available informal support, social workers will have to allocate notional packages of support on the basis of notional informal care provision.

- Given many individuals will be assessed only to receive 'notional' financial packages of support, gaming may result, such as households overstating disability, hiding financial resources or understating their ability to provide informal care.
- The Commission acknowledges that the threshold of the cap would have to increase over time to reflect inflation and changes in unit care costs, and a clear, predictable process would be required to determine this.
- Given local authority discretion on care spending, any new funding directed to local authorities may require new measures to ensure it is used for this purpose.
- The current government has set out plans to reform local business rates, and this will have to be taken account of in any plans to implement the 'capped cost' model.

What are the choices for policymakers?

What are the key choices for policymakers going forward in relation to the recommendations of the Commission on Funding of Care and Support? One option would be to implement the 'capped cost' model in full.

A second option would be to set out plans to implement the model in part or in stages, taking account of the fiscal environment and the capacity of the social care system to adapt to new arrangements. For example, the government could implement different components of the model at different times, e.g. the £100,000 threshold for residential care followed some years later by the £35,000 cap on care costs. Alternatively, the government could implement the model in full, but in a much less generous form (e.g. a £80,000 cap), that became more generous over time.

If the government were concerned with doing everything it could to encourage private insurance, it could adopt a carer-blind 'accumulated disability' model instead of the Commission's carer-sighted 'capped cost' model. However, there would be complex trade-offs involved.

Alternatively, the government could enable individuals to insure themselves against the £35,000 liability by letting individuals 'buy their way out' of the means-test through the operation of state-sponsored insurance schemes at a national level, or local schemes operated by individual local authorities.

Finally, many of the challenges around using local authority needs-assessments to allocate 'notional packages of support' could be addressed through applying 'matching contributions' in the social care system, and this would represent a further variant of the 'capped cost' model for policymakers to explore.

Conclusion

The principal long-term care funding challenge that existed before the appointment of the Commission remains the same now: how to find new funding to meet growing demand for the current system, with the amount required by the social care system in England set to increase by £8.3 billion by 2025.

The long-term care funding system has long needed a new and specific stream of funding to cope with this rising demand. The Commission was not directed to define what that revenue stream should be. Instead, the Commission has set out an aspiration for what the 'shape' of state support should be, representing a fairer partnership between the individual and state.

The principal strength of the Commission's capped cost model is that it is built around an indisputable truth: only the state can coordinate protection against catastrophic care costs for the population, so the state must step in and provide this protection.

The key criticism that can be made of the 'capped cost' model is that against a backdrop of rising demand, population ageing and a difficult fiscal outlook, most of the *additional* cost posed by the 'capped cost' model would be spent on the top two income quintiles of older people.

It will be up to the government to decide how to balance the delivery of a right to protection from catastrophic care costs with the need to target resources in the context of a fiscally-constrained system.

Given that most of the extra spending required by the 'capped cost' model would go to wealthier households, stakeholders are likely to insist that it is wealthier older households who shoulder the additional costs of implementing the model.

In maintaining a significant role for local discretion in the social care system, even in the context of a reformed FACS framework, there is a risk that councils will seek to manage their budgets in the context of a duty to deliver a £35,000 cap by reducing notional and actual entitlement.

Going forward, the government should take forward those recommendations of the Commission that do not require major new

expense: scaling up the Deferred Payment Scheme; reforming FACS; and, enabling portable needs assessments. The government should also proceed with piloting key aspects of the ‘capped cost’ model as soon as possible.

When policymakers have formed a judgement about the deliverability of the ‘capped cost’ model, politicians can then make a judgement about priorities, and which step the implementation of the ‘capped cost’ model should represent in the ongoing process of long-term care funding reform. While the Commission has set out a compelling proposal for eliminating some of the disastrous consequences of the current system for some families, politicians must not be distracted from the bigger of issue of how to drive significant, new funding into the social care system to cope with rising demand.

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