



A Cap that Fits

The 'capped cost plus' model



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Executive Summary

This report aims to help policymakers prepare for reform of long-term care funding in England from April 2016.

Despite the political commitment to implementation of the ‘capped cost’ model, a growing number of commentators and stakeholders have highlighted questions and issues for the ‘capped cost’ reforms. These issues include:

- ▶ The ‘capped cost’ model will not in fact cap people’s care costs given most individuals pay more for care than their local authority, particularly in residential care;
- ▶ Despite the government promoting the new Upper Capital Limit in 2016 for means tested support for residential care costs of £118,000, few, if anyone, will actually receive financial support when they spend down their wealth to this level. There will in effect be 152 different ‘real’ Upper Capital Limits across England.

Ultimately, if such issues remain unaddressed, this could see:

- ▶ Anticipated benefits of the reforms - such as greater peace of mind among the older generation - lost in conflicting messages around the true implications of the reform for individuals;
- ▶ A backlash from the public against the reforms, resulting in a loss of interest among politicians in reform of long-term care funding;
- ▶ The transfer to other areas of public spending of the £1 billion earmarked by HM Treasury to pay for reform of care funding in England.

All citizens have an interest in the best possible reforms to care funding in England being implemented in April 2016. In this context, the purpose of this report is to:

- ▶ Identify and explore the key issues and problems for the ‘capped cost’ reforms, particularly relating to issues of risk and feasibility;
- ▶ Develop and evaluate potential ‘fixes’ for these issues;
- ▶ Provide recommendations to policymakers about the design and nature of reforms to long-term care funding that should be implemented in April 2016.

The report identifies a number of issues around the ‘capped cost’ reforms, and potential options for policymakers, arranged sequentially in the order they are likely to emerge as significant, up to and beyond 2016.

The issue	The options
“Councils are struggling to implement the reforms”	1: Implement the ‘capped cost’ reforms in stages
	2: Enable councils to implement the reforms at a time of their choosing
“The reforms are making it harder to integrate	1: Withdraw home care from the ‘capped cost’

health and social care”	reforms and develop new ways to apply the ‘capped cost’ principle coherent with integrated care
“People can’t buy insurance against the £72,000 liability”	1: Enable individuals to ‘buy’ a lower ‘cap’ through a charge on their estate
“The cap is scaring and confusing people”	1: Adopt alternative measures of care costs
	2: Introduce an additional, static ‘years of care’ cut-off period
“The ‘cap’ does not cap ‘Moderate’ need care costs”	1: Lower the threshold of qualifying needs under the ‘capped cost’ reforms from Substantial to Moderate.
	2: Extend entitlement to means tested support to Low and Moderate needs, but retain the threshold for ‘metered’ expenditure at Substantial
“The reforms are encouraging families to play the system”	1: Replace purely notional Personal Budgets with low-level co-payments
	2: Narrow the Upper and Lower Capital Limits
“Few at the ‘Upper Capital Limit’ are receiving support from their council”	1: Index the Upper Capital Limit to what councils pay for residential care in England
	2: Raise the Lower Capital Limit
	3: Change the ratio used to calculate ‘tariff income’
“The ‘cap’ isn’t capping care costs”	1: Change the language around the ‘capped cost’ model
	2: Clarify ‘council-rate’ fees
	3: Intervene in care markets to align ‘council-rate’ fee levels with prices for self-funders
	4: Clarify the ‘council rate’ in terms of quality
	5: Extend options for asset protection by building ‘top-up’ immediate needs annuities into the ‘capped cost’ reforms
	6: Build top-up INAs into the ‘capped cost’ offer with ‘capped premiums’
	7: Build INAs into the ‘capped cost’ offer with ‘capped premiums’ and ‘star ratings’

The report concludes by assembling different options for into an alternative reform package that could be implemented in 2016, entitled ‘capped cost plus’. This would have the following features:

For home care:

- ▶ Capped integrated home care costs via a weekly cap on charges of £100 per week.

Why? Withdrawing home care from the ‘capped cost’ model will enable the continued integration of health and social care in England. It will give local government and the NHS the

flexibility required to implement new models of health and social care funding, commissioning and provision. A weekly cap on means tested charges, uprated over time with inflation, will provide clarity and peace of mind, and protect individuals from catastrophic care costs.

For residential care:

- ▶ Introduce an additional ‘years of care’ cut-off period alongside the £72,000 ‘cap’

Why? The existing ‘cap’ on residential care proposed for 2016 of £72,000 will potentially create confusion and fear. An additional ‘years of care’ cut-off period, set at around five years, will be the same across the country and over time, providing a consistent point of reassurance to households.

- ▶ A single Capital Limit for residential care of £70,000

Why? Variations in the ‘usual cost’ rate by councils, and the additional incentive to engage in deliberate deprivation among families, undermines the rationale for an Upper Capital Limit of £118,000 in 2016. Although representing a ‘cliff-edge’ in entitlement, a single Capital Limit of around £70,000 will provide greater simplicity and clarity.

- ▶ Build top-up INAs into the ‘capped cost’ offer with ‘capped premiums’

Why? Differences between the prices paid for residential care by local authorities and self-funders are inevitable, but pose a fundamental challenge to the ‘capped cost’ reforms. By guaranteeing that self-funders can access a ‘top-up INA’ priced at a fair, ‘community-risk’ rated level, the ‘capped cost plus’ model will offer transparency and greater certainty to self-funders.

- ▶ Enable individuals to buy a lower ‘cap’ through a charge on their estate

Why? Individuals should be able to protect themselves from the liability they are left with for residential care costs under the 2016 reforms. Since the private sector will be unable to offer such protection, the state must step in and make this available instead. Enabling pre-commitment to an optional charge, paid from estates and uprated annually with inflation, will ensure cost-neutrality for the Exchequer, but give those who choose it access to a £0 ‘cap’.

‘Capped cost plus’: What will it look like to users?

- ▶ Before needing care

“If I receive care in my home, I won’t be charged more than £100 per week. If I move into a care home, I am guaranteed to receive support for at least ‘council-rate’ care’ after five years, no matter where I live or when I move into residential care. If I want to have access to non-means tested care in future, I have the option of paying an estate charge.”

- ▶ Upon receiving home care

“I am not paying more than £100 per week for integrated health and care services in my

home.”

- ▶ Upon moving to residential care

“I am paying more than the council-rate for residential care in my area. However, my local authority has given me the option to pay a ‘top-up’ premium, which will mean that all of my care costs are taken care of for the rest of my life once I reach the ‘cap’.

Part 1

1. Introduction

1.1 Introduction

This report aims to help policymakers prepare for reform of long-term care funding in England from April 2016.

In the 2010 ‘programme for government’, the Coalition Government committed to:¹

“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 Coalition (2010) Our programme for government

In July 2010, the Coalition Government launched the Commission on Funding of Care and Support, chaired by Andrew Dilnot. The final report of the Commission – entitled ‘Fairer Care Funding’ - was published in July 2011. The Commission proposed a ‘capped cost’ model of long-term care funding in England, built around the core principle that it is the responsibility of the state to protect individuals from the risk of catastrophic social care costs, given private insurance is incapable of offering such protection.²

February 2013

On February 11th 2013, the Secretary of State for Health announced to the House of Commons that the Coalition would implement the recommendations of the Commission on Funding of Care and Support from April 2017. The Secretary of State said the measures announced by the government would bring:

“a new degree of certainty, fairness and peace of mind to the costs of old age, disability and living with long-term conditions, while ensuring that the greatest level of financial support goes to those with the greatest need.”

Hansard, 11 Feb 2013: Column 592

The key components of the announcement comprised:

- ▶ **A ‘cap’ on the assessed care costs that individuals have to pay** during their lifetime set at £61,000 in 2010-11 prices or £75,000 once introduced in April 2017;
- ▶ **An increase to £123,000 in the ‘Upper Capital Limit’ means test threshold** applied by local authorities for adult social care support.

To fund this additional state support for the costs of care to individuals, the Secretary of State said the extra £1 billion cost of the reforms by 2020 would be met:

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

part of the introduction of the single-tier pension.”

Hansard, 11 Feb 2013: Column 593

In an accompanying ‘policy statement’,³ the government also confirmed that:

- ▶ For adults receiving residential care, it would **increase the lower threshold for the means test in line with indexation** from its 2010-11 value of £14,250 which, subject to assumptions, would mean a starting value of around £17,500 in 2017;
- ▶ **Individuals will remain responsible for a contribution towards general living costs** in residential care, set at around median pensioner income of £10,000 in 2010-11 prices (equivalent to around £12,000 in 2017-18) to help meet expenses associated with room and board. In domiciliary care, people will remain responsible for non-care expenses such as utilities and rent;
- ▶ **The cost of meeting people’s eligible needs will count towards the cap** – rather than their financial contribution (i.e. what they actually pay for care).

By fixing an implementation date for reform and specifying how reforms would be paid for, one of the most important results of the government’s announcement was political: to create a political imperative for all the major UK political parties to enter the 2015 general election with a clear, funded plan to implement reform of long-term care funding in England.

Following the government’s public commitment to the ‘capped cost’ model, the Chancellor of the Exchequer subsequently announced in March 2013 that implementation of the reforms would be brought forward by one year, and would instead take place **in April 2016**.

Adjusting the various thresholds for inflation, implementation of the reforms in 2016 will see a **‘cap’ of £72,000 and an Upper Capital Limit for residential care of £118,000, both of which will be uprated in 2017 and successive years.**

1.2 A cap that fits?

Despite the political commitment to implementation of the ‘capped cost’ model, a growing number of commentators and stakeholders have highlighted questions and issues for the ‘capped cost’ reforms. These issues include:

- ▶ The ‘capped cost’ model will not in fact cap people’s care costs given most individuals pay more for care than their local authority, particularly in residential care;
- ▶ Despite the government promoting the new Upper Capital Limit in 2016 for means tested support for residential care costs of £118,000, few, if anyone, will actually receive financial support when they spend down their wealth to this level. There will in effect be 152 different ‘real’ Upper Capital Limits across England.

Ultimately, if such issues remain unaddressed, this could see:

- ▶ Anticipated benefits of the reforms - such as greater peace of mind among the older generation - lost in conflicting messages around the true implications of the reform for individuals;

- ▶ A backlash from the public against the reforms, resulting in a loss of interest among politicians in reform of long-term care funding;
- ▶ The transfer to other areas of public spending of the £1 billion earmarked by HM Treasury to pay for reform of care funding in England.

All citizens therefore have an interest in the best possible reforms to care funding in England being implemented in April 2016. In this context, the purpose of this report is to:

- ▶ Identify and explore the key issues and problems for the ‘capped cost’ reforms, particularly relating to issues of risk and feasibility;
- ▶ Develop and evaluate potential ‘fixes’ for these issues;
- ▶ Provide recommendations to policymakers about the design and nature of reforms to long-term care funding that should be implemented in April 2016.

In **Chapter 2**, the report sets out the detail of the government’s ‘capped cost’ reforms to care funding that are due to be implemented in 2016.

The report then identifies and explores a broad range of issues confronting the reforms. These issues are organised sequentially relating to when, leading up to and beyond 2016, they are likely to be widely acknowledged and may result in negative headlines.

▶ **Part 2: The route to 2016**

This section of the report discusses issues that will be encountered leading up to implementation in 2016.

▶ **Part 3: Implementation**

This section examines broad challenges and issues for the reforms relating to their interaction with the general public from 2016, such as the non-availability of insurance products in relation to the £72,000 ‘liability’, as well as the fear that may be stoked among the older population by annual increases in the level of the ‘cap’.

▶ **Part 4: Metering**

The fourth part of the report examines issues around the operation of the reforms, such as the exclusion of private expenditure on Moderate needs, and incentives for families to game the system.

▶ **Part 5: The ‘cap’**

This section of the report explores in detail why the ‘cap’ is not a cap, what the risks arising from this are and what the government can do.

Part 6 of the report concludes by assembling different options for into an alternative reform package that could be implemented in 2016, entitled ‘capped cost plus’.

2. The ‘capped cost’ model

2.1 Introduction

The ‘capped cost’ model comprises several distinct components:

- ▶ A ‘cap’ on the assessed care costs that individuals are expected to pay for out of their own pocket;
- ▶ Changes to means testing thresholds and the financial support individuals receive proportional to their level of wealth;
- ▶ A standardised expected contribution by individuals to ‘living costs’ in residential care.

In addition, various other reforms to long-term care funding are being implemented by the government alongside the ‘capped cost’ model; in particular, the implementation of ‘deferred payment schemes’ among all local authorities to enable those funding their own residential care to request their local authority pays their fees with a loan repaid subsequently at a time of their choosing.

2.2 The underlying principle

The ‘capped cost’ model is built around a core principle: it is the responsibility of the state to protect individuals from so-called ‘catastrophic’, accumulated care costs. This principle stems from several observations:

- ▶ Civilised societies engage in risk-pooling in relation to adverse risks;
- ▶ Pooling the risk of catastrophic care costs is an economically rational activity for citizens, given the potential for so-called ‘catastrophic’ care costs, i.e. accumulated care costs that use up the vast majority of a person’s wealth;
- ▶ Private insurance – the principal alternative to pooling risk via the state – for catastrophic care costs is impossible owing to the distinct nature of such risks, which result in market failure for pre-funded care insurance.

More detail on the rationale for the principle of state protection from catastrophic care costs is set out in Appendix 1.

2.3 The £72,000 ‘cap’ on costs

The central feature of the ‘capped cost’ reforms is a ‘cap’ on the assessed private costs of care to individuals.

Under the ‘capped cost’ model, the care costs that will be ‘capped’ will be defined using local authority needs assessments and mechanisms for allocating resources:

- ▶ Any person presenting themselves for assessment to their local authority will be given an **assessment of need**. Those individuals assessed as having **Substantial** or **Critical** care

and support needs using the 'Fair Access to Care Services' (FACS) criteria will be classed as having 'eligible needs'. Those individuals assessed as having Low or Moderate needs will not;

- ▶ Local authorities will then determine the weekly cost of care that someone with 'eligible needs' requires using a **Resource Allocation System** (RAS) or equivalent, taking into account someone's level of disability, a person's preferences and the outcomes they want to achieve, the resources available to the local authority to spend on supporting adults, as well as the 'unit cost' of care in the local market. This assessment will result in a Personal Budget expressed as the financial value of support that a council assesses someone as requiring;
- ▶ Local authorities will then give individuals a **means assessment**, taking into account their total income and 'assessable wealth' – i.e. ability to pay – in order to determine the total weekly cash value that someone will receive from the local authority toward their care costs;
- ▶ Higher income and wealth individuals who do not receive the full value of their Personal Budget from their local authority following the means assessment will be deemed to be meeting these costs privately;
- ▶ This assumed private expenditure will be 'metered' on a weekly basis by the local authority using '**Care Accounts**'. When these Care Accounts reach £72,000, a person will be entitled to the full financial value of their Personal Budget as a payment from their local authority.

As this description shows, a key feature of the 'capped cost' model is that it does not cap private expenditure on care (i.e. the cash people 'hand over' to pay for their care), but rather, the total accumulated value of means tested financial support that individuals are excluded from by their local authority owing to their wealth.

It is also important to note that individuals below retirement age will be subject to a different level of 'cap'. People who have eligible needs when they turn 18 will receive free lifetime care to meet their eligible needs, and those with eligible needs who are below state pension age will be subject to a lower cap.⁴

2.4 Changes to the 'capital limits'

As part of a **means assessment** for determining how much financial support individuals receive, local authorities take into account '**assessable wealth**', which is wealth that individuals are expected to draw upon in addition to their income in order to pay for their care costs. This approach recognises that even when a person has a relatively low income, they could have a high level of savings or wealth that it is reasonable to expect them to draw upon to fund their care costs.

The value of a person's home is not regarded as assessable wealth, unless a person has moved out of it and no partner or dependent is living there.

For the purpose of the means test, the assessed value of a person's savings and assets are converted into notional 'tariff income', which is then added to a person's actual income to determine a total assumed income. Under the ratio used to calculate 'tariff income', £250 of

assessable wealth is treated as £1 of income per week. For example, £10,000 of assessable wealth is treated as £40 of tariff income per week.

Under current means test rules, tariff income is calculated on a person's wealth between a Lower Capital Limit of £14,250 and an Upper Capital Limit of £23,250.

The government has announced that from April 2016,

- ▶ The 'Upper Capital Limit' will be raised to £118,000 when the value of a person's home is included (i.e. for residential care);
- ▶ Where the value of someone's home is not counted (i.e. domiciliary care), the 'Upper Capital Limit' will be raised to £27,000.
- ▶ The 'Lower Capital Limit' will be increased to £17,000 in April 2016.⁵

This means that from April 2016, tariff income will be calculated on the basis of assessable wealth between £17,000 and £118,000 for those in residential care, and £17,000 and £27,000 for those receiving care at home. These thresholds will subsequently be updated on an annual basis in line with inflation or an equivalent measure.

The effect of these proposals will be to increase the amount of financial support that self-funders in residential care with assets below the Upper Capital Limit are entitled to receive.

Importantly, those people with assessable wealth above the Upper Capital Limit are not entitled to any financial support from their local authority.

2.5 The standardised contribution to 'living costs' in residential care

The Commission on Funding of Care and Support argued that it was reasonable to expect individuals to make a contribution toward their 'living costs' in residential care, since they would have to pay such living costs regardless of whether or not they are in residential care.⁶ However, the Commission argued that 'living cost' contributions should be standardised, predictable and transparent.

The government accepted this recommendation and has announced that a standardized contribution to living costs of around £12,000 a year (£230 per week) will be introduced from April 2016 for those in residential care, which is roughly equivalent to median pensioner income.⁷

Importantly, for the purposes of metering a person's care costs and their progress toward the £72,000 'cap', these contributions will not count towards the 'cap'. So, for example, if the assessed Personal Budget of someone in residential care were £480 per week, their meter would increase by this amount minus their assumed 'living cost contribution' of £230 per week, i.e. by £250 per week.

2.6 The benefits of the reforms

The government has described the benefits of implementing the 'capped cost' model as follows:

- ▶ These changes will make the funding of care and support in England fairer for all and more sustainable.
- ▶ For the first time, from April 2016, people will have more certainty on how much they should have to pay for care. People will no longer face the prospect of potentially unlimited care costs. Those who can afford to pay for their care will be more able to proactively plan and make provision to access the kind of care and support they would want in later life.
- ▶ Everyone will have this reassurance, not just the 16% of older people who need care who face care costs of £72,000 or more. This will empower people to take responsibility for their care in line with what they can afford. Everyone will be protected against unlimited care costs. And state support will be targeted for the people who need it most.
- ▶ In advance of this, from April 2015, people needing residential care will have access to deferred payment agreements in every local authority in England. This means people will no longer face the added stress of having to rush into selling their home to pay for care home fees and will have the flexibility to avoid selling their home within their lifetime.
- ▶ Taken together these reforms will establish a new long-term partnership between government and individuals.
- ▶ These changes will also mean more people will involve their local authority in their care, either as a result of extended access to financial support or so as to benefit from the cap on care costs. This will provide a huge opportunity for local authorities to support people to maintain their independence, remain active and connected in their communities and stay healthier for longer.

Source: Department of Health (2013)⁸

As described in the Introduction, various commentators have questioned whether these benefits will be realised in practice.

Part 2: The route to 2016

3. “Councils are struggling to implement the reforms”

The ‘capped cost’ reforms represent a transformation of long-term care funding in England, and pose a major implementation challenge to local authorities in the context of budget pressures and wider systemic reforms.

3.1 What’s the issue?

In addition to implementing the ‘capped cost’ reforms in April 2016, local authorities in England confront a number of other challenges, raising questions over their ability to implement reforms successfully, in full, in 2016.

3.2 Background

Local authorities adult services departments confront significant pressures in the period leading up to April 2016 and beyond it. First and foremost, these pressures are budgetary:

- ▶ Resource pressures on the care system in England resulting from cuts to local government funding;
- ▶ Rising demand for care owing to population ageing;
- ▶ Funding pressures on the NHS with potential knock-on implications for usage of social care services;

In addition, the implementation of reforms to care funding in England must take place in the context of wider systemic changes in the health and care system:

- ▶ The implementation of the Adult Social Care Outcomes Framework;
- ▶ The Care and Support Bill, expected to be passed by June 2015, which will place various new responsibilities on local authorities;
- ▶ The reorganisation of the NHS, following the Health and Social Care Act (2012) is resulting in radical changes to the health system of England with unknown consequences for health services, and by extension, the social care system;
- ▶ Integration of health and social care - in the 2013 Spending Round announcement, HM Treasury announced that for 2015-16, it would put £3.8 billion in a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities.⁹ It is widely expected that future health and care budgets will also be pooled in this way.

More information on these pressures on the care system and the drivers behind them are set out in Appendix 2.

Finally, it is important to highlight the feasibility challenges involved in implementing the ‘capped cost’ reforms:

- ▶ Undertaking needs and means assessments for 125,000 'self-funders' in residential care in England and 325,000 older people funding their own home care;¹⁰
- ▶ Undertaking needs and means assessments for individuals who may not use care currently but could present themselves for an assessment following publicity around the reform, potentially including up to 1 million older people who currently receive Attendance Allowance but do not receive local authority support;¹¹
- ▶ Creating and administering 'Care Accounts' for those assessed as having qualifying needs.

3.3 Why does this matter?

If local authorities become overwhelmed in terms of budgets or organisational capacity by implementing the 'capped cost' reforms in April 2016, this could have negative implications for:

- ▶ Individuals with care and support needs, for example, in the form of 'waiting lists' for needs assessments;
- ▶ Individuals with qualifying needs, who may see their actual or notional Personal Budgets reduced as councils cope with the financial pressures on them;
- ▶ Other local authority services, if additional finances have to be diverted into adult services;
- ▶ Care providers, if local authorities look to save money by putting further pressure on the fees paid to providers.

3.4 Option 1: Implement the 'capped cost' reforms in stages

In order to reduce the feasibility challenge of reform to local authorities, the government could introduce the 'capped cost' reforms across England in stages:

- ▶ Year 1: Increase the Upper Capital Limit to £118,000;
- ▶ Year 2: Initiate 'Care Accounts' for those in residential care;
- ▶ Year 3: Introduce Care Accounts for those receiving domiciliary care.

Pros

- ▶ Staging implementation would considerably reduce the probability of local authority social services departments being overwhelmed by competing pressures around 2016.

Cons

- ▶ Staging implementation over several years would require extending the publicity activity around the reforms, increasing costs and potentially making communication more difficult.

3.5 Option 2: Enable councils to implement the reforms at a time of their choosing

Recognising the diversity of demands and pressures placed on different local authorities, the government could let councils implement the different stages of the 'capped cost' reforms at a time of their own choosing during the 2015-2020 parliament.

Pros

- ▶ Reduced chance of local authorities encountering significant difficulties with

implementation;

- ▶ Scope for 'early adopter' councils to provide lessons to subsequent waves of councils implementing the changes.

Cons

- ▶ Would create an additional 'postcode lottery' across the country, potentially creating confusion for families.

3.6 Conclusion

Independent of reforms to care funding in England, the local authority care system confronts a uniquely challenging period up to April 2016. Staged implementation of care funding reforms, or greater flexibility for councils would reduce the probability of problems resulting in knock-on consequences for care users, providers and other services.

4. “The reforms are making it harder to integrate health and social care”

The NHS and local government have been directed by Westminster to integrate health and social care, but this could be made more difficult – and new models of integrated care undermined - by the implementation of the ‘capped cost’ reforms.

4.1 What’s the issue?

Despite pressure from central government, implementation of the ‘capped cost’ model is likely to make it harder for the NHS, local government and service providers to achieve the integration of health and social care funding, commissioning and provision, particularly in relation to home care.

4.2 Background

There is growing interest among policymakers and politicians in the integration of health and social care funding, commissioning and provision, in order to:

- ▶ Enable efficiencies from joint commissioning of services, reduce overlap and enable integrated provision of health and care;
- ▶ Eliminate ‘cost shunting’ between health and care providers and budgets;
- ▶ Enable investment in cost effective social care preventative interventions from NHS budgets, so that limited resources are spent more efficiently, e.g. £100 on a handrail to prevent a fall rather than £5,000 on treatment in a fractures clinic.

The cross-party House of Commons Health Committee has repeatedly argued that given demographic and fiscal pressures on health and care budgets:¹²

“the breadth and quality of services will only be maintained and improved through the full integration of commissioning activity across health and social care.”

The Committee has also cited evidence that up to 30% of admissions to the acute sector are unnecessary or could have been avoided if the conditions had been detected and treated earlier through an integrated health and care system.

Responding to growing interest in integrated care, the Coalition Government used its 2013 Spending Round to announce that for the financial year 2015-16, it would be:

“...putting £3.8 billion in a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities. This shared pot includes an additional £2 billion from the NHS and builds on the existing contribution of around £1 billion in 2014-15, with the aim of delivering better, more joined-up services to older and disabled people, to keep them out of hospital and to avoid long hospital stays.

4.3 The interaction between integrated care models and the ‘capped cost’ reforms

Various different models of integrated care funding, commissioning and provision exist. However, more ambitious models that may potentially secure the greatest benefits, such as full budget pooling and joint commissioning of health and care, would require flexibility in:

- ▶ How ‘social care’ versus ‘health’ needs are defined;
- ▶ Who provides services;
- ▶ Who pays for services, i.e. the NHS, local authorities or the service user.

Crucially, in order to spend pooled health and social care budgets in the most cost effective way, it is likely that support will need to be allocated in a way that cuts across the current FACS eligibility framework used by local authority adult services departments, as well as existing rules on means testing and charging.

The proposal for fully integrated health and care budgets implies the replacement of the current risk-based FACS model for allocating support for care costs in England with a model that also prioritises the allocation of support on the basis of preventing need for acute care. Indeed, in its most radical form, ‘integrated care’ involves dissolving the whole notion of a defined social care ‘need’ or ‘cost’. Instead, with a single budget and a single outcomes framework, there would simply be needs and commissioned services, some of which individuals may be charged for.

In this context, it appears that there is a tension between the ‘capped cost’ model - built around the standardised metering of notional, assessed ‘social care’ costs by local authorities using current needs assessments – and different models of integrated health and care funding, commissioning and provision. The ‘capped cost’ reforms effectively place social care in isolation from the rest of the care pathway, potentially making it more difficult for models of integrated care to prevent acute admissions, provide for care needs at home and keep people out of hospital.

In short, implementation of the ‘capped cost’ model appears incoherent with potential future measures to integrate health and social care in England.

Such issues are less pertinent to residential care – where models of provision are unlikely to change substantially and care costs can more easily be defined – compared to home care, which could in future be absorbed by integrated providers of primary and personal care services in the community, funded via single budgets.

4.4 Why does this matter?

In the context of an ageing population and projections of rising health and care costs to the Exchequer in future, there is growing acceptance of the need to undertake radical reconfiguration of the health and care systems in England, so as to do ‘more with less’. Although policy debate on different models of integrated care continues to evolve, it appears that implementing integrated care could be made significantly more difficult if the local

authority social care system in England is 'locked in' to existing definitions of social care needs and costs because of the 'capped cost' model.

What can the government do about this?

4.5 Option 1: Withdraw home care from the 'capped cost' reforms and develop new ways to apply the 'capped cost' principle coherent with integrated care

In order to apply the principle of capping people's care costs, without undermining or preventing progress toward greater integration of health and social care, policymakers need to ensure total flexibility in:

- ▶ What is defined as social care needs or services;
- ▶ Whether services are funded by local authorities, the NHS or the individual;
- ▶ What services individuals receive for free.

Given pressures on public spending, it is unlikely that moves to integrate health and social care will result in all health and social care provided free at the point of use, up to and beyond 2016.

If means testing is therefore to be preserved, alongside flexibility over what is defined as 'social care' and the principle of capping people's care costs, this suggests policymakers may need to implement:

- ▶ A new charging framework for ongoing health and care services provided in a person's home, e.g. a new 'community services charge';
- ▶ Limits on the amounts that individuals have to pay for community service charges, in order to cap people's costs.

Crucially, both the unit cost and typical weekly cost of providing integrated health and care services in someone's home may be far higher than existing packages of home care support. This in turn suggests the need to:

- ▶ Bring all individuals with support needs into the scope of means tested support, rather than just those who, as now, have less than £23,250 in wealth;
- ▶ Cap the weekly amount that individuals have to pay for care.

The model of weekly caps on expenditure has already been adopted by local authorities in Wales, where home care users cannot be charged more than £50 per week for care services by local authorities.¹³ In effect, for wealthier individuals, the first £50 of weekly care costs have to be met privately, but costs in excess of this amount are met by the local authority. In this way, the financial support provided by councils is targeted at those with the most expensive care needs, and individuals are protected from catastrophic costs.

In addition to a weekly cap on care costs, policymakers could also implement an accumulated lifetime cap on the community services charges that individuals have to pay. This could be measured in terms of:

- ▶ A financial cap, such as £72,000;
- ▶ A ‘years of care’ cap, that limits the number of years that individuals are expected to contribute toward means tested community service charges;
- ▶ Both of the above.

Pros

- ▶ Withdrawing home care from the ‘capped cost’ reforms and developing new approaches to charging for integrated health and care services, such as a ‘community services charge’, with appropriate limits on what people pay (e.g. a £100 per week cap) would both facilitate the integration of health and social care, while also protecting individuals from catastrophic costs.

Cons

- ▶ This option would represent a radical change in the provision of health and social care services and charging in the community, therefore bringing with it new implementation challenges.

4.6 Conclusion

The drive among policymakers to integrate health and social care funding and delivery potentially poses the most acute challenge to the ‘capped cost’ reforms to care funding in England.

In this context, a logical response by policymakers would be to pre-empt and enable further integration of health and social care by redesigning the ‘capped cost’ model so as to facilitate greater integration of health and social care.

This may require the withdrawal of home care from the ‘capped cost’ reforms, and rethinking what people are required to pay for integrated health and care services in the home, and how individuals are protected from catastrophic costs.

Part 3: Implementation

5. “People can’t buy insurance against the £72,000 liability”

Implementation of the ‘capped cost’ model will not result in a pre-funded insurance market, making it impossible for individuals to prepare for their £72,000 liability, except to undertake ordinary saving.

5.1 What’s the issue?

The ‘capped cost’ model is likely to fail in one of its key objectives: enabling individuals to prepare for the costs of care through the purchase of pre-funded insurance.

5.2 Background

A key purported benefit of the ‘capped cost’ model has always been the development of complementary financial products that would enable individuals to prepare (insure) against the cost of future care needs.

The government has stated:

“Our care reforms will mean people have more opportunity to financially plan. People will not face unlimited costs but will instead have a more realistic amount towards which to financially plan. The cap should also improve the affordability and relevance of products... We expect financial services to respond in time for 2016. We think a range of solutions will develop for people at different stages of their life, including people with different levels of wealth. These will need to be affordable and work coherently with both the cap on care costs and the financial assessment. We want to see products help people pay for domiciliary as well as residential care whilst supporting families and carers as well as those who need care. Participation by a wider range of firms is likely to benefit everybody by improving competition and choice.”

Source: Department of Health (2013)

No country in the world has a properly functioning market in pre-funded social care insurance.¹⁴ At present, no insurance companies offer pre-funded care insurance in the UK, whether as a standalone product, or embedded within a so-called ‘disability-linked annuity’ purchased with a pension pot at retirement. Previous analysis by the Strategic Society Centre has identified multiple demand and supply-side barriers to the development of such products.¹⁵ Supply-side barriers include:

- ▶ Limited profitability and market size;
- ▶ Uncertainty posed by longevity and morbidity risk;
- ▶ Possible adverse selection;
- ▶ Requirement for a new system of needs (claims)-assessments;
- ▶ Reputation risk.

Demand-side barriers include:

- ▶ The high cost of the products relative to average savings and income;
- ▶ The typical requirement by products for out-of-pocket payments on care;
- ▶ Competing financial motives among households;
- ▶ Precautionary saving in response to other types of household ‘protection gap’ risks besides care costs;
- ▶ Uncertainty over availability of informal care and consequent need for paid care;
- ▶ Uncertainty over who to insure in a household;
- ▶ ‘Political risk’ and uncertainty in relation to availability and shape of state support in the future;
- ▶ Uncertainty regarding future household wealth in relation to the means test, and whether households have an interest in insuring themselves;
- ▶ Confusion among households in England with Scotland’s system of universal free personal care;
- ▶ ‘Mental discounting’ of the risk of needing care;
- ▶ Distrust of financial services providers;
- ▶ Obligation to obtain paid financial advice.

5.3 Will the ‘capped cost’ reforms enable the development of pre-funded insurance?

There are no credible reasons to believe that the implementation of the ‘capped cost’ model in April 2016 will result in the development of pre-funded insurance products for care costs, and specifically, in relation to the £72,000 liability. At a general level, the ‘capped cost’ reforms represent a very limited response to the multiple entrenched demand and supply-side barriers to this market described above.

However, the ‘capped cost’ reforms also have a number of important features that make the emergence of a pre-funded care insurance market unlikely:

- ▶ The promotion of the £72,000 ‘cap’ may lead many households to conclude there is no point in obtaining protection;
- ▶ The £72,000 liability will be uprated annually with inflation, and for individuals to purchase complementary inflation-proofed payouts on an insurance policy will be extremely expensive, given uncertainties for insurers around future inflation rates;
- ▶ Given it is determined by local authority needs assessments, a person’s £72,000 liability measured using a ‘Care Account’ is ‘uninsurable’, in that no insurer can predict when someone’s meter will begin and when they will reach the ‘cap’. This has very negative implications for the ‘consumer experience’ in relation to any complementary pre-funded insurance. For example, individuals might make a successful claim on a care insurance product but be told by their local authority that they do not have any qualifying care needs because they are able to rely on informal care;
- ▶ Because the ‘capped cost’ reforms will not cap people’s care costs, anyone who bought a product that paid out £72,000 (uprated) would still find themselves having to pay out-of-pocket payments toward their care costs. Individuals would have to be made aware of this by Independent Financial Advisors at the point of purchase, and may therefore be demotivated to purchase a product.

Multiple stakeholders, including the Association of British Insurers and the UK's leading provider of 'immediate needs annuities' for care costs,¹⁶ have stated they do not believe the 'capped cost' reforms will lead to a market in pre-funded care insurance.

5.4 Why does this matter?

Informing individuals that they will not have to pay more than £72,000 in care costs invites them to ask: "how can I protect myself from paying the £72,000?"

If the government does not have an answer to this question, the public's response to the 'capped cost' reforms may be negative or dismissive, undermining the aims of the reforms.

5.5 Option 1: Enable individuals to buy a lower 'cap' through estate charges

In the absence of a private insurance response to the £72,000 liability, the government could enable individuals to lower their 'cap' to £0, i.e. non-means tested care, through the payment of a one-off 'charge'.

A major uncertainty around the £72,000 liability is how it will be updated each year. For the same reason that insurers would be unable to price a pre-funded one-off lifetime insurance product for 60-year olds that paid out £72,000 updated with inflation, the government would expose itself to risk and uncertain liabilities if it enabled, e.g. 60-year olds to pay a one-off charge that lowered their 'cap' to £0, because the government could have no idea what the true value of the benefit to individuals would be at the time they need care.

Instead, the government could enable individuals to lower their 'cap' to £0 through a pre-committing to pay charge on their estates, with the amount to be paid at death updated each year in line with inflation. For example, in 2016, such a charge could be set at £20,000, but in opting to reduce their 'cap' to £0, individuals would have accepted that the final figure would only be determined at the time of their death, having been updated in line with inflation (and the level of the 'cap').

5.6 Conclusion

The 'capped cost' reforms are set to fail in one of their key objectives: to enable individuals to protect themselves from the £72,000 'liability', which could have significant implications for public attitudes to the reforms. In the absence of a private sector response, the government may have to step in and implement its own mechanisms for individuals to protect themselves. In order to address uncertainties posed by inflation and the updating of the 'cap', this would likely to take the form of a charge on people's estates.

6. “The ‘cap’ scaring and confusing people”

Families may be left scared or confused, firstly, because of annual increases in the value of the ‘cap’, and second, wide variation across England in how long it takes to reach the ‘cap’.

6.1 What’s the issue?

The ‘cap’ on care costs and the thresholds used in means testing financial support will be increased in line with inflation. However, these annual changes could undermine the extent to which the reforms secure their objectives for peace of mind among the population.

6.2 Background

The £72,000 ‘cap’ on care costs to be introduced in 2016, as well as the Upper and Lower Capital Limits used in local authority means tests, will be uprated (increased) every year in line with inflation, in order to ensure that the generosity and cost to the Exchequer of the reforms remain consistent over time.

For example, a reasonable projection of increases to changes to the £72,000 ‘cap’ in 2016 would be £75,000 in 2017, £78,000 in 2018, etc.

However, annual increases to the ‘cap’ on assessed care costs may undermine any peace of mind families feel as a result of the ‘cap’. Indeed, it is arguably likely that the uprating of the ‘cap’ may have the opposite effect to that desired, creating fear, confusion and disengagement.

Such risks may be considered acute for several reasons:

- ▶ During periods of relatively high inflation but low interest rates, such as experienced by older people in England during 2009 to 2013, people’s income and savings may be losing value in ‘real terms’ because they are not rising in line with inflation. As such, during such periods in future, the ‘cap’ on care costs will actually become more expensive for households in real terms;
- ▶ More widely, it is worthwhile noting that the value of the likely annual increase in the ‘cap’ following 2016 of around £3,000 is actually more than most households save during a 12-month period.

6.3 Vignette

Mrs Smith is 70 in April 2016 and does not have any care needs. She has savings of £20,000, a home worth £230,000, and a total income of £170 per week.

Mrs Smith takes an interest in her future potential care needs and after seeking out information, is reassured to be told her total assessed care costs will be capped at £72,000.

The period 2016 to 2019 is characterised by high inflation, sluggish house price growth and low interest rates.

By 2019, Mrs Smith has savings of £20,250, a home worth £235,000 and a total income of £190 per week. Mrs Smith begins to experience substantial disability for the first time, and although she remains able to cope on her own, she investigates again what support she is entitled to.

After consulting her council, Mrs Smith is alarmed to discover that her care costs will now be capped at £82,000, and so she writes to her MP to complain about the increase in the 'cap', which means that she will have to spend a greater proportion of her assets on her care.

6.4 Why does this matter?

A central aim of the 'capped cost' reforms is to achieve peace of mind among the population about their protection from catastrophic care costs. However, by uprating the value of the 'cap' and means test thresholds with inflation, there is a strong risk that the 'capped cost' reforms will leave individuals in a continual state of alarm at their growing liability for their care costs, i.e. that it will have precisely the opposite effect intended.

6.5 What's the issue?

Considerable local variation will exist in when individuals reach the 'cap', potentially creating confusion among the public and undermining the aims of the reforms around clarity and peace of mind.

6.6 Background

The 'cap' on private expenditure on assessed care costs under the 'capped cost' reforms is fixed at £72,000, and progress toward the 'cap' will be metered on the basis of a council's 'usual cost' rate minus the standardised 'living cost' contribution of £230 per week.

However, because of differences in 'usual cost' rates across England, in part reflecting differences in local care markets, there will be very large differences in when individuals reach the 'cap'.

6.7 Vignette

Mrs Smith moves into residential care in Wigan aged 85 in April 2016, becoming the first person to be 'metered' under the new system.

She has assets totalling £250,000 (including the value of her home, which is subsequently sold) and a total income – including disability benefits – of £250 per week.

Her local authority's 'usual cost' benchmark rate for residential care is £405 per week. This is the most her local authority will pay for a place in residential care. So, Mrs Smith's 'meter' only increases by this amount minus her notional £230 per week 'living cost' contribution, i.e. by

£175 per week. On this basis, it will take Mrs Smith around **eight years** to reach the ‘cap’.

Mrs Smith has an identical twin sister – Mrs Jones - who moves into residential care in Surrey aged 85 in April 2016, becoming the second person to be ‘metered’ under the new system.

She has assets totalling £250,000 (including the value of her home, which is subsequently sold) and a total income – including disability benefits – of £250 per week.

Her local authority’s ‘usual cost’ benchmark rate for residential care is £680 per week. So, £450 is the weekly progress she makes toward the £72,000 ‘cap’. On this basis, it take Mrs Jones just over **three years** to reach the ‘cap’.

6.8 Why does this matter?

To meet its objectives, the ‘capped cost’ model needs to enhance peace of mind among the (older) population about how much they will have to spend on care. Although a single ‘cap’ of £72,000 across England will apply, this will mean very different things when measured in ‘years of care’ that people pay for before they reach the ‘cap’, which could be anything between three and 8 years in different parts of the country.

Many people will learn about the ‘cap’ on care costs by talking to friends and family, and it is inevitable that some people will talk about the ‘cap’ in relation to how many years in residential care that someone will have to pay for before they reach the ‘cap’.

Ultimately, the wide differences in how long it takes people to reach the ‘cap’ could create confusion, misunderstanding as well as accusations of unfairness, since people are far more likely to live for three years in a care home than for eight.

Indeed, this feature of the ‘capped cost’ model may have awkward political implications, if Members of Parliament begin to compare how long it takes individuals in their constituency to reach the ‘cap’ compared to individuals elsewhere.

6.9 Option 1: Adopt alternative measures of care costs

The government could meter the amount of time that individuals have to pay for their care in terms of time, rather than accumulated assessed care costs.

For example, the government could say:

- ▶ “Everyone across the country will receive their council’s ‘usual cost’ rate for care after they have paid for **three years** in a care home privately.”

In addition to being simple, such a ‘cap’ would be consistent across the country and could also remain the same over many years, while costing the same to the Exchequer in real terms.

Pros

- ▶ By remaining static over time and uniform across the country, a time-based ‘cap’ would

pose less risk of confusion and alarm than metering individuals in terms of notional care costs.

Cons

- ▶ A time-based 'cap', such as three years, would create significant inequalities in how much individuals were expected to pay for their care costs before reaching the 'cap'.

6.10 Option 2: Introduce an additional, static 'years of care' cut-off period

In addition to the operation of metered Care Accounts under the 'capped cost' reforms, with the 'cap' uprated annually from £72,000 in 2016, the government could introduce a cut-off period beyond which all individuals are entitled to the local authority 'usual cost' rate for residential care, even if they have yet to reach the £72,000 'cap'. For example, this cut-off period could be set at five years.

This would enable the government to say:

- ▶ "Everyone will receive their council's 'usual cost' rate for care once their assessed care costs reach £72,000, or once they have spent five years paying for their own residential care."

Pros

- ▶ A 'five-year' cut-off period would remain constant over time and be the same across the country, providing an alternative source of reassurance to families than the 'cap', which will change each year and vary considerably in how long it take to reach.

Cons

- ▶ A 'years of care' cut-off period for residential care may increase costs to the Exchequer.

6.11 Conclusion

Metering private expenditure on care purely on the basis of notional, assessed care costs may cause fear among households and confusion over disparities in how long it takes to reach the 'cap'.

Although a purely time-based approach to metering care costs brings with it its own inequalities and variations, a 'years of care' cut-off period would provide greater security and consistency to the protection provided by the reforms.

Part 4: Metering

7. “The ‘cap’ does not cap ‘Moderate’ need care costs”

Private expenditure on care to meet ‘Moderate’ needs are not included in the ‘cap’ on costs.

7.1 What’s the issue?

Private expenditure on care and support by individuals assessed by their local authority as having Low or Moderate needs will not be recognised by the ‘capped cost’ reforms.

7.2 Background

Under the ‘capped cost’ reforms, only individuals assessed by their local authority as having Substantial or Critical needs on the existing ‘FACS’ scale will be regarded as having qualifying needs, and therefore awarded an actual or notional Personal Budget. Individuals assessed as having Low or Moderate needs may be compelled to spend their private resources on care to meet these needs, including spending down their wealth.

7.3 Why does this matter?

If someone experienced Moderate needs for a long period, such as ten years, they may build up very large accumulated care bills. However, none of this private expenditure will be recognised by local authorities under the ‘capped cost’ reforms; indeed, the person will not have a Care Account, and in the eyes of their local authority will not have had any care costs.

Crucially, although the cost of meeting Low or Moderate needs through private support will typically be lower than Substantial or Critical needs, and many individuals may therefore be able to fund such care from their income, in some instances, individuals may have to spend down their wealth to meet these needs.

As such, by ignoring long-term private expenditure on support to meet Low or Moderate needs, the protection from ‘catastrophic costs’ provided by the ‘capped cost’ reforms is undermined. This is particularly important because receipt of care when a person has Low or Moderate needs may delay or reduce the subsequent onset of Substantial or Critical needs.

7.4 Vignette

Mrs Smith is 75, lives at home, and pays £65 per week for care and support that enables her to remain independent. She has a total income of £200, so she pays for her care through £45 from her income and £20 per week by drawing on her savings.

Her needs are assessed by her local authority who judge her to have Moderate needs, and as such, she is not entitled to a Personal Budget nor a Care Account.

Mrs Smith's care and support needs do not change, and she continues to spend £65 per week on care and support for five years. By this time, she has spent £16,900 on care, including £5,200 from spending down her savings.

At the age of 80, Mrs Smith is reassessed by her local authority as having Substantial needs and a Care Account is set up on her behalf. However, the £16,900 she has already spent on her care, including £5,200 from capital, is not considered by her council and her Care Account begins from zero.

7.5 Option 1: Lower the threshold of qualifying needs under the 'capped cost' reforms from Substantial to Moderate.

Pros

- ▶ This measure would significantly reduce the extent of individuals spending down their savings to meet their Moderate needs.

Cons

- ▶ The cost of the reforms to the Exchequer would increase substantially.

7.6 Option 2: Extend entitlement to means tested support to Low and Moderate needs, but retain the threshold for Care Accounts and 'metered' expenditure at Substantial

Pros

- ▶ By reducing the qualifying needs threshold for means tested financial support to Moderate needs, but not for entitlement to a Care Account, the government could ensure that individuals can afford to meet their Moderate needs from their income and not have to spend down their savings, but limit the cost of making the system more generous in this way.

Cons

- ▶ Costs to the Exchequer.

7.7 Conclusion

By setting the needs threshold for qualifying for local authority support at Substantial under the 'capped cost' reforms, the government will ensure some people accumulate very high private care bills that are never recognised in the financial support provided by local authorities.

To address this issue, the government could extend greater means tested financial support to those with Moderate needs to ensure such costs can primarily be met from income rather than spending down wealth, even if the threshold for 'Care Accounts' remains at Substantial.

8. “The reforms are encouraging families to play the system”

The ‘capped cost’ reforms will see the local authority care system move from a ‘safety-net’ to an ‘all-in’ system, but one which continues to ration support. This could have significant consequences for ‘gaming’ of the system by families.

8.1 What’s the issue?

The different components of the ‘capped cost’ model introduced in April 2016 could encourage families to ‘game’ the local authority care system in various ways, in order to extract as much financial support as possible from the system.

8.2 Background

‘Gaming’ is often defined as using the rules and procedures of a system in order to manipulate it for a desired outcome.

It is generally acknowledged that some gaming of the local authority care system in England already occurs. For example, despite rules in relation to ‘deliberate deprivation of assets’ – i.e. families hiding or moving around wealth to ensure that someone is entitled to mean tested support from the council - it is generally accepted that some families do engage in this form of gaming.

However, the implementation of the ‘capped cost’ model will potentially increase the scope for gaming of local authority assessments for both needs and means.

8.3 Gaming needs assessments under the ‘capped cost’ model

Under the ‘capped cost’ model, all households with a care need will be incentivised to:

- ▶ Seek a needs assessment as early as possible;
- ▶ Seek to qualify for support under the needs assessment particularly in relation to home care, e.g. by understating the availability of informal care from family members;
- ▶ Maximise the value of their notional Personal Budget that is metered via a Care Account if households are above the means test thresholds, whether through pressuring local authorities and disputing notional Personal Budget awards, or deliberately gaming the assessment process.

The potential for disputes under the ‘capped cost’ reforms have already been noted by the Joint Committee on the Draft Care and Support Bill:

“The introduction of a capped cost scheme, which will result in many more people being assessed and entitled to a personal budget, is likely to lead to an increase in disputes and legal challenges.”

Source: Joint Committee on the Draft Care and Support Bill (2013)

In addition to uncertainties around how households will respond to incentives under the 'capped cost' model, it is also worthwhile highlighting uncertainty around how social workers will respond to implementing notional Personal Budgets, and other aspects of the 'capped cost' model. Indeed, despite national 'Fair Access to Care Services' (FACS) guidance, local authority needs assessments primarily comprise subjective judgements by social workers. A 2013 survey of 300 social workers found that one quarter admitted to exaggerating older people's disabilities in order to ensure they qualified for local authority support.¹⁷ However, policymakers have no evidence on whether such behaviour will increase when social workers allocate notional Personal Budgets to individuals with high levels of need.

8.4 Vignette

Mrs Smith is 72 and lives alone. She has substantial care needs that are met by her daughter, Alice, aged 51, who lives close by and has moved from full to part-time work in order to be able to visit Mrs Smith twice a day to help her dress, bathe and eat.

After reading about the introduction of the 'capped cost' reforms and the recommendation on the website of an older people's charity that everyone with a care need should seek assessment, Alice approaches her local authority to request a needs assessment for her mother. Alice knows that with £30,000 of savings, her mother would be unlikely to qualify for support, but she would like to ensure that her mother's Care Account is set up and running, so that she will reach the 'cap' as quickly as possible should she later move into a care home.

The local authority undertakes the needs assessment but decides that Mrs Smith does not have any qualifying needs because of the care and support provided by Alice.

Surprised at this decision, Alice continues to read online and discovers that if she tells the local authority that she is no longer able to provide informal care, and if she buys in formal care from a home care agency for several weeks, this will force the local authority to set up a Care Account that will meter Mrs Smith's care costs.

Alice requests another needs assessment for her mother, but arranges for a home care agency to visit her mother for 2 hours a day during the week prior to the assessment, frequently sitting in on these visits herself.

At the new needs assessment, Alice explains that she is no longer able to provide informal care herself owing to the need to return to full-time employment, and the family has been forced to buy in paid care, showing the social worker the invoices they have accrued.

Following the assessment, the local authority determines that Mrs Smith has Substantial needs, and given her level of savings, awards her a notional Personal Budget of £100 per week, which is metered in her Care Account.

Having secured the notional Personal Budget and a Care Account for her mother, Alice stops the visits from the home care agency and continues to provide informal care, visiting her mother twice a day.

8.5 Option 1: Replace purely notional Personal Budgets with low-level co-payments

To reduce incentives for families to game needs assessments for home care under the ‘capped cost’ model, the government could replace fully ‘notional’ Personal Budgets with low-level co-payments, for example, worth 10% of the value of someone’s Personal Budget.

This measure would mean that all individuals with qualifying levels of need would receive something from their local authority, rather than just those who are above the means test threshold only receiving ‘notional’ support.

Pros

- ▶ Families and social workers would feel that people with care needs were at least receiving some support from their local authority, rather than a purely ‘notional’ amount, potentially making them less inclined to engage in ‘gaming’;
- ▶ Families would have to show how they were spending the money received as a Personal Budget, so would be less likely to game the needs assessment in order to boost the value of the notional Personal Budget.

Cons

- ▶ Costs to the Exchequer.

8.6 Gaming means assessments under the ‘capped cost’ model

Under the ‘capped cost’ model, the new Upper Capital Limit for residential care of £118,000 in 2016 (subsequently updated in future years) will be promoted to the public as the threshold of means tested support.

Encouraged to plan ahead by the government, this new means test threshold may see far more families encouraged to engage in ‘deliberate deprivation’ in order to maximise their financial support.

In this context, it is useful to review average levels of total wealth in the older population, which provide an indication of how many individuals may have to move only relatively small amounts of wealth in order to potentially qualify for means tested support.

The following chart shows net total wealth (including savings and property wealth) for the whole older population in England in 2010. The chart also shows average total wealth for the over 1 million older people who receive Attendance Allowance in England, who represent a better match with individuals who may be more likely to approach their local authority after April 2016 for a needs assessment.

Net total wealth, England	65+ Population	AA Recipients
25th percentile	£95,700	£6,000
50th percentile (median)	£210,007	£127,010

75th percentile	£359,000	£218,148
95th percentile	£870,000	£479,006
Average (mean)	£299,574	£151,168

Source: Attendance Allowance in England (2013)¹⁸

The table shows that among the 1.3 million older people who qualify for the disability benefit Attendance Allowance, around half have total wealth below or just above the level of the new Upper Capital Limit for residential care. More widely, among the whole 65+ population, around 30% have wealth at this level.

These figures suggest that as more families are encouraged to plan ahead following the implementation of the ‘capped cost’ model in 2016, the increase in the Upper Capital Limit for residential care may see significantly more families incentivised to move assets and wealth around in order to qualify for more means tested financial support.

8.7 Vignette

Mrs Smith is 72, lives alone, and receives informal care from her daughter Alice, who visits her twice a day.

Aware that in future her mother may move into residential care, Alice has read about the means test threshold for financial support of £118,000. At present, Mrs Smith has £128,000 of wealth, comprising a £103,000 home and £25,000 in savings. After discussing the reforms to care funding together, Mrs Smith and her daughter decide to move £20,000 of her savings into a savings account in her daughter’s name, thereby reducing her wealth to £108,000.

Two years later, Mrs Smith is admitted to residential care. Her council estimates her total wealth as £108,000, which is below the Upper Capital Limit means test threshold, and so she becomes entitled to means tested support for her care costs from her first day.

8.8 Option 2: Narrow the Upper and Lower Capital Limits

Individuals with assets below, or not far above, the £118,000 Upper Capital Limit for residential care will in 2016 have strong incentives to engage in ‘deliberate deprivation’: every £1 they transfer to a family member will increase the amount of financial support they subsequently become entitled to.

In this context, the government may wish to consider how to reduce the prevalence of households that are incentivised to engage in deliberate deprivation. This could be achieved by:

- ▶ Increasing the Lower Capital Limit for residential care from £17,000, thereby increasing the prevalence of households who would gain nothing from engaging in deliberate deprivation;
- ▶ Lowering the Upper Capital Limit for residential from £118,000, thereby increasing the prevalence of households who would need to engage in a significant amount of ‘deliberate deprivation’ before they would be entitled to means tested support.

The government could also replace the two Capital Limits with a single Capital Limit, such as £70,000.

Pros

- ▶ Lowering the Upper Capital Limit, or narrowing the gap between the two capital limits, would reduce the prevalence of families strongly incentivised to engage in deliberate deprivation by the 'capped cost' reforms.

Cons

- ▶ Changes to the capital limits for residential care could make the reforms more expensive for the Exchequer.

8.9 Conclusion

The current local authority care funding system in England includes incentives for families to potentially game the system.

However, by encouraging far more families to 'go through the doors' of the local authority, many of whom will only then receive 'notional support', the 'capped cost' model may not only lead to more disputes between families and councils, but gaming. In addition, the increase in the Upper Capital Limit for residential care may provide a target for many older people to transfer their assets in order to ensure they qualify for means support.

In response to these issues, the government could introduce co-payments for home in order to reduce the scope and motivation for gaming, and change the capital limits for residential care so as to reduce incentives to engage in deliberate deprivation.

9. “Few at the ‘Upper Capital Limit’ are receiving support from their council”

Increasing the Upper Capital Limit to £118,000 for those in residential care will see few who spend down their wealth to this level actually receive support for care costs.

9.1 What’s the issue?

Despite the government promoting the new Upper Capital Limit in 2016 for means tested support for residential care costs of £118,000, few, if anyone, will actually receive financial support when they spend down their wealth to this level. There will in effect be 152 different ‘real’ Upper Capital Limits across England.

9.2 Background

The Coalition Government accepted the recommendation of the Commission on Funding of Care and Support to raise the Upper Capital Limit for residential care, which will be £118,000 from April 2016.

The rationale for raising the Upper Capital Limit is to improve the capital protection of the ‘capped cost’ model for lower-wealth groups, and therefore the overall distributional impact of the ‘capped cost’ reforms and the additional public spending it requires. For example, without the raised Upper Capital Limit, a self-funder in residential care could spend down their wealth from £98,000 to £27,000 by around the time they reached the ‘cap’, which would represent around 72% of their wealth. In contrast, someone with £250,000 upon going into residential care would only need to spend down around one fifth of their wealth before reaching the ‘cap’, such that a greater proportion of their wealth is protected by the ‘capped cost’ reforms (assuming, as described above, that such a person paid care fees equivalent to that paid by their local authority).

If instead the Upper Capital Limit had been higher, such as £118,000, for the lower-wealth individual moving into residential care with £98,000, this person would have been entitled to means tested support from the outset.

9.3 What financial support will people receive with £118,000 of wealth?

Despite theoretically representing the threshold of entitlement to financial support, a £118,000 ‘Upper Capital Limit’ applied in the means test for financial support for residential care costs will likely see very few individuals entitled to support at this point.

Why? In 2016, someone with £117,750 of capital (i.e. just below the new Upper Capital Limit) of capital would have £101,000 of ‘assessable wealth’ (£118,000 minus the raised Lower Capital Limit threshold of £17,000).

In local authority means assessments, £101,000 of assessable wealth would be calculated as 'tariff income' at a rate of £1 per week of income for every £250 of assessable wealth, i.e. a tariff income of £404 per week.

So, a council would say to an individual with £117,750 of capital: "you can afford to contribute £404 per week to your care costs from your capital."

The council would also expect self-funders to make a contribution from their income. The projected median income of pensioners in 2016 will be £230 per week, or £12,000 per year.

So, excluding details such as the 'Personal Expenditure Allowance', if a person has £101,000 of 'assessable wealth', a council would regard someone as being able to pay £634 per week (£404 + £230) toward residential care fees.

However, according to data collected by a market research company, the average 'usual cost' rate paid by local authorities for residential care in 2012-13 was £480 per week.¹⁹ Uprated for inflation to 2016 prices, this would be around £550 per week.

If the average local authority 'usual cost' rate is £550 per week, and someone with £117,750 of wealth – below the Upper Capital Limit - is assessed as having a total assumed income of £634 per week, this person would receive nothing from their council.

In fact, a self-funder would only become entitled to £1 per week of support when their assessable wealth had dropped considerably further. Assuming someone had median pensioner income of £230 per week, and the 'usual cost' rate was £550 per week, someone would need to have less than £320 per week in 'tariff income' to be entitled to support. For a person's tariff income to equal £320 per week, they would require 'assessable wealth' of £62,600.

After allowing for the amount of a person's wealth protected by the Lower Capital Limit, this means that the 'real' Upper Capital Limit – the point that the average self-funder will become entitled to means tested financial support – is equal to £17,000 plus £62,600, i.e. £79,600.

In short, the average real 'Upper Capital Limit' in 2016 for a pensioner with median income will be £79,600.

Importantly, because the Upper Capital Limit is standardised across the country, but the 'usual cost' rate paid by local authorities for residential care varies across 152 authorities, there will in fact be 152 'real' Upper Capital Limits in force from 2016.

9.4 Why does this matter?

This aspect of the 'capped cost' reforms creates a number of risks:

- ▶ Disappointment, confusion and anger among self-funders who reach the 'Upper Capital Limit', and their families, who find they have to carry on spending down their wealth beyond £118,000 before they receive any financial support from their local authority. There may be a particular risk of a backlash from residential care users around April 2016 when many

individuals already in residential care with less than £118,000 of wealth may expect to become entitled to financial support, only to discover they are not;

- ▶ Reduced peace of mind about the protection from catastrophic costs provided by the ‘capped cost’ reforms;
- ▶ Consequences for the distributional impact of the reforms, particularly in relation to lower-wealth households.

To avoid the accusations of misleading people, the government has several options.

9.5 Option 1: Index the Upper Capital Limit to what councils pay for residential care in England

Indexing the Upper Capital Limit to the highest amount that any council in England pays for residential care would enable the government to say:

- ▶ “People funding their own residential care with this level of wealth, or less than this amount, will receive some financial support for the costs of care in some parts of the country.”

Indexing the Upper Capital Limit to the median amount that councils pay for residential care would enable the government to say:

- ▶ “In at least half of local authority areas, people funding their own residential care with this level of wealth, or below it, will receive some financial support for the costs of care.”

Indexing the Upper Capital Limit to the lowest amount that any council pays for residential care would enable the government to say:

- ▶ “Every self-funder in England with wealth below this level will be entitled to means tested support, and in many places, they will receive support before they reach this level”.

Pros:

- ▶ Represents an improved ‘guarantee’ for the financial support that will be provided.

Cons:

- ▶ The Upper Capital Limit will move year to year not in line with inflation (a transparent approach), but with variations in what councils pay for residential care on average (an unpredictable approach).

9.6 Option 2: Raise the Lower Capital Limit

In order to narrow the gap between the Upper Capital Limit and Lower Capital Limit, the government could also raise the Lower Capital Limit for residential care. For example, a Lower Capital Limit of £55,400 and an Upper Capital Limit of £118,000 would ensure the average self-funder was entitled to financial support from their council, once they had £118,000 or less of wealth, assuming the average local authority ‘usual cost’ rate was £550 per week.

9.7 Option 3: Change the ratio used to calculate ‘tariff income’

In order to ensure that all self-funders in residential care with £118,000 of wealth or below are entitled to at least some financial support, the government could modify the ‘tariff income’ ratio of £250 of assessable wealth to £1 of income per week used by local authorities in means assessments.

For example, a £315: £1 tariff income ratio would ensure that someone with £118,000 of wealth would be entitled to financial support from an average local authority whose ‘usual cost’ rate was £550 in 2016.

9.8 Conclusion

This chapter has explored how one of the central promises made for the ‘capped cost’ reforms – that individuals with less than £118,000 of wealth will be entitled to financial support for their care costs from their local authority - will in fact be untrue in the majority of cases.

To address this issue, the government could index the level of the Upper Capital Limit to local authority ‘usual cost’ rates, raise the Lower Capital Limit or change the tariff income ratio that councils use.

In addition to the issues around the Upper Capital Limit identified in this chapter, there remain additional issues relating to the rules around ‘living cost’ contributions and Attendance Allowance, and these are set out in Appendix 3.

Part 5: The 'cap'

10. “The ‘cap’ isn’t capping care costs”

This chapter examines the central challenge confronting the ‘capped cost’ model: the nature of the ‘cap’ on costs.

10.1 What’s the issue?

The ‘capped cost’ model will not cap people’s care costs - because of the difference between what private individuals pay for care (especially residential care), and local authority ‘usual cost’ rates, i.e. the standard amount that a council pays for care.

10.2 Background

The vast majority of domiciliary and residential care in England is provided by the independent sector, with prices determined by the operation of market forces.

Most local authorities have a ‘usual cost’ rate which is the standard amount they will pay for different types of domiciliary and residential care, but which are almost always below the average amount that private individuals pay for care.

In some instances, this price difference will reflect differences in quality, and will reflect an active choice by families to pay for more expensive services given their available income and wealth. However, in many instances the difference in average prices paid for care results from the exercise of market (monopsony) power by local authorities who pay for approximately two-thirds of care home places in England, and can use this power to negotiate lower rates.

Indeed it is widely accepted that in response to the downward pressure on fee levels paid by local authorities, some residential care providers are then forced to charge more to private individuals in order to remain sustainable, effectively resulting in a ‘cross-subsidy’ from self-funders to local authorities.

10.3 What does this mean for the ‘capped cost’ model?

The difference between what self-funders and local authorities pay for care has very significant implications for the operation of the ‘capped cost’ model.

In particular, this means that a person’s Personal Budget – i.e. the cost of care they are assessed as requiring by their local authority – will almost always be lower than their actual private expenditure on care.

Ultimately, this undermines the extent of asset protection provided by the ‘capped cost’ model:

- ▶ By the time individuals reach the ‘cap’, the vast majority will have paid more toward their care costs than £72,000, even after taking account of ‘living cost’ contributions;

- ▶ Beyond the ‘cap’, individuals will go on making out-of-pocket payments for their care costs because their Personal Budget will be lower than what they pay for care. For some self-funders in residential care, this could amount to hundreds of pounds each week.

In short, the ‘capped cost’ model will not cap the private costs of care.

10.4 Why does this matter?

The fact that the ‘capped cost’ model will not cap people’s care costs may result in:

- ▶ Disappointment, confusion, shock and anger among self-funders who reach the ‘cap’, and their families;
- ▶ The reforms having little or no impact on peace of mind among older people about future potential catastrophic care costs as it becomes widely known that the reforms do not cap people’s care costs;
- ▶ A backlash from the public against politicians who may be accused of ‘lies’ or ‘fraud’ relating to the extent of asset protection provided by the reforms;
- ▶ A decline in public trust and expectations around the care system, ultimately making it harder for politicians in future to maintain political support for public expenditure on the care system.

10.5 Vignette

The following vignette explores this issue from the perspective of the ‘user journey’. For the sake of simplicity, certain details found in the current system, such as the ‘Personal Expenditure Allowance’, are excluded.

Mrs Smith moves into residential care aged 85 in April 2016, becoming the first person to be ‘metered’ under the new system.

She has assets totalling £250,000 (including the value of her home, which is subsequently sold) and a total income – including disability benefits – of £250 per week.

She pays £650 per week for her place in an average care home, using all of her income on her care fees, and therefore spending down her assets at a rate of £400 per week to cover the difference.

Her local authority’s ‘usual cost’ benchmark rate for residential care is £550 per week. This is the most her local authority will pay for a place in residential care. So, Mrs Smith’s ‘meter’ only increases by this amount minus her notional £230 per week ‘living cost’ contribution, i.e. by £320 per week.

In other words, £320 is the weekly progress she makes toward the £72,000 ‘cap’.

After 225 weeks in residential care (around 4.3 years) at around August 2020, Mrs Smith’s Care Account reaches the £72,000 ‘cap’.

However, at this point, she has spent around £146,250 on care fees, and has spent down her

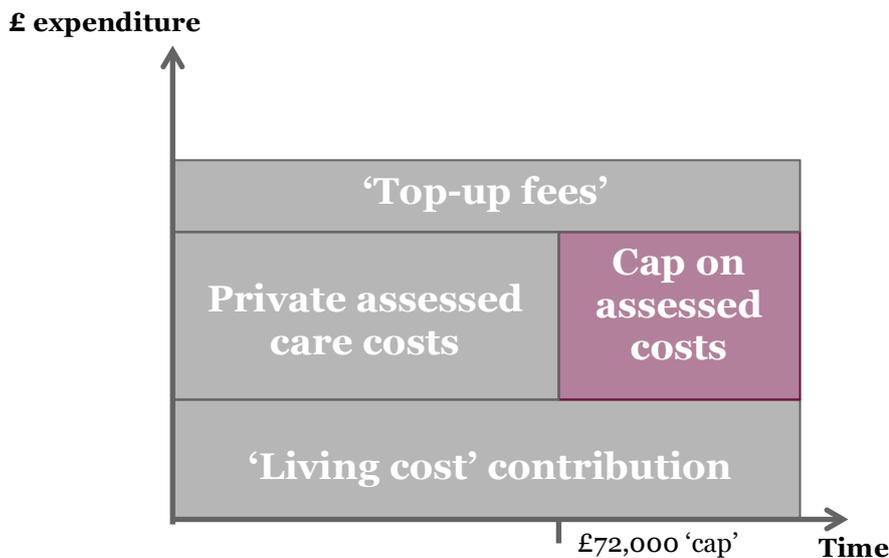
capital by around £90,000.

From this point, she receives £320 per week from the local authority.

However, this still leaves her with a shortfall, and so she pays the remaining fees of £330 per week herself, comprising £250 from income and £80 per week from depleting her capital.

So, a year after she has reached the 'cap', she has depleted her assets by a further £4,160, and carries on doing so.

This feature of the 'capped cost' model can be presented as a chart:



What can policymakers do in response to this issue?

10.6 Option 1: Change the language around the 'capped cost' model

The government could implement the 'capped cost' reforms, but cease referring to the "capped cost model" and cease making claims that people's care costs will be 'capped'. In effect, the government could 'scale down' the claims made for the reforms and associated public expectations, in order to close the 'perception gap' between public expectations of the reforms and what they will mean in practice.

Pros:

- ▶ Lack of disruption to implementation plans.

Cons:

- ▶ The government would be giving up attempts to provide reassurance or peace of mind to the older population in relation to care costs, despite the significant additional public expenditure required by the reforms.

10.7 Option 2: Clarify ‘council-rate’ fees

The government could change the way in which the ‘capped cost’ reforms are presented by emphasising that costs are only metered at the ‘council rate’, and individuals will only receive a ‘council rate’ contribution to their care costs upon reaching the ‘cap’. For example:

- ▶ “When you reach the ‘cap’, you will receive the value of ‘council-rate’ fees from your council, equivalent to the standard amount the council pays.”

Pros:

- ▶ Lack of disruption to implementation plans.

Cons:

- ▶ Potential for confusion;
- ▶ Unclear how the progress of Care Accounts to the £72,000 could be explained in terms of ‘council-rate’ fees.

10.8 Option 3: Intervene in care markets to align ‘council-rate’ fee levels with prices for self-funders

The government could intervene in care markets to align ‘usual cost’ rates paid by councils and the prices that self-funders pay for equivalent services. This would be complex to engineer and may require substantial changes to the operation of care markets, but could conceivably be achieved in a number of ways, for example:

- ▶ Routing all local authority and self-funder procurement of care via third-party ‘care brokers’;
- ▶ Regulating the prices charged by providers proportional to quality;

While not all self-funders would end up paying the same as their local authority given the preferences of wealthier individuals for more expensive care, the ‘capped cost’ reforms would be substantially more meaningful if it was always and everywhere possible for a self-funder to purchase care at the same rate as the council.

Pros:

- ▶ For some people, the ‘capped cost’ reforms genuinely would cap costs, because they would pay the same fees as their care as their local authority, ensuring that their private expenditure would be aligned with their Care Account.

Cons:

- ▶ Many individuals would still be exposed to catastrophic care costs via ‘top-ups’;
- ▶ Uncertainty around consequences for care markets, providers and local authorities, of potential interventions to align prices paid;
- ▶ By reducing the extent of cross-subsidy from self-funders, local authority ‘usual cost’ rates would have to rise, increasing costs to councils.

10.9 Option 4: Clarify the ‘council rate’ in terms of quality

Individuals may struggle to understand the concept of a ‘usual cost rate’ or ‘council-rate’ care. However, more may be able to understand the concept that councils will only pay for a defined level of quality of care.

So, rather than clarifying the ‘usual cost’ rate that individuals will receive under the ‘capped cost’ model, councils could express this in terms of a ‘quality rating’. For example:

- ▶ “Worthenshaw Council will pay for 3* rated residential care. If you move into a 3* home, your care costs will be capped at £72,000. However, if you move into a 4* or 5* home, your fees may be more expensive and you will have to pay ‘top-up’ fees.”

Pros:

- ▶ The concept of a ‘council rate’ quality of care may be the most intuitive and understandable way of expressing the ‘usual cost’ rate that is metered under the ‘capped cost’ model.

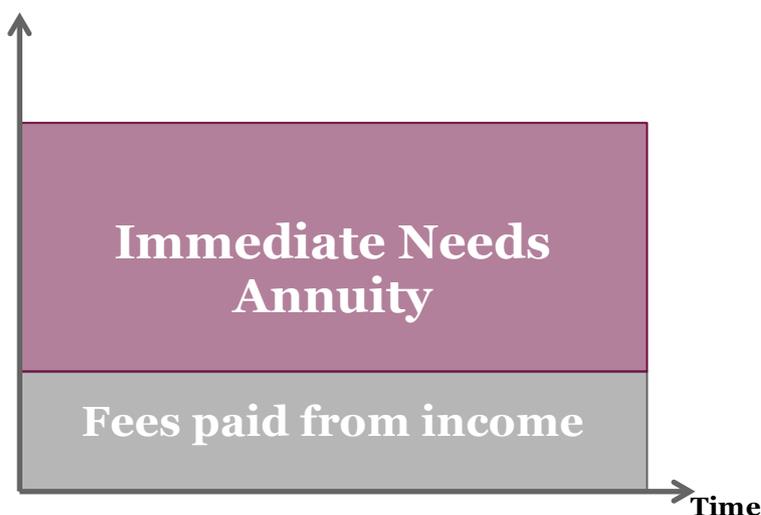
Cons:

- ▶ Would require substantial interventions in care markets to align ‘usual cost’ rates with quality of care homes, which may in turn have a number of unintended consequences on the operation of the market.

10.10 Option 5: Extend options for asset protection by building ‘top-up’ immediate needs annuities into the ‘capped cost’ reforms

Immediate needs annuities (INAs) are a type of insurance product that protect individuals in residential care from catastrophic care costs in return for a large-up front premium. For example, upon entering residential care, a self-funder might pay an £85,000 premium in return for a £400 per week income. This income is payable for the rest of their life until their death, whether that is after two years or 10 years, and would usually give them enough – in addition to their pension income - to pay for all of their care fees without spending down their capital.

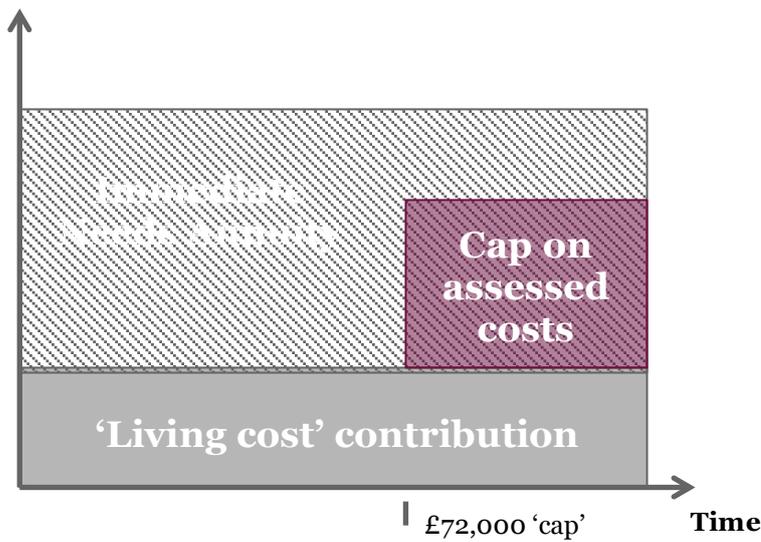
£ expenditure



There are estimated to be around 7-8,000 INAs currently in force in England.²⁰ INAs are not suitable for all self-funders; rather, individuals must have a substantial level of wealth from the outset for it to be actuarially worthwhile for them to protect this wealth. Academic estimates of the potential size of the INA are around 45,000 of 125,000 self-funders in England.²¹

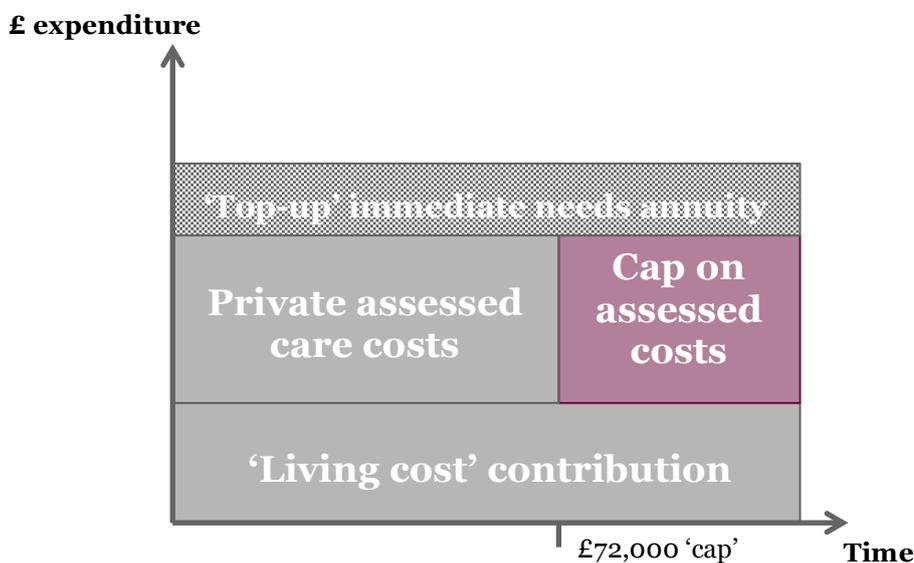
However, variants of traditional INAs are possible, which could be designed to act in conjunction with the 'capped cost' model, and enhance the asset protection available to individuals.

For example, after paying their 'living costs' from income, individuals could use an INA to cover all their remaining care costs, including 'top-up' costs beyond the 'cap':



However, such an INA would still be expensive for most self-funders.

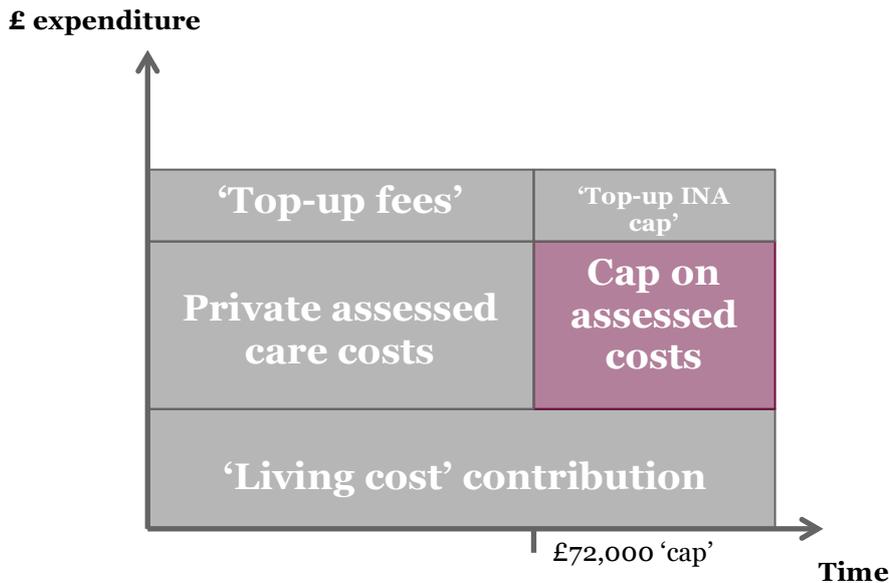
Alternatively, a 'top-up' INA could be provided that would pay an income for the rest of someone's life to cover the difference between the local authority's 'usual cost' rate, and the additional 'top-up' difference with what the person actually pays:



Upon entering residential care, a local authority could then advise:

- ▶ “The local authority rate is £530 per week, but for the care home you have chosen, you will pay ‘top-up’ fees of £100 per week. In return for a one-off premium of £20,000, your ‘top-up’ fees will be paid for life, and you will not subsequently have to spend more than £72,000 on your remaining care costs.”

A third, even cheaper alternative would be for the top-up INA to begin payments to coincide with a person reaching the ‘cap’:



Upon entering residential care, a local authority could then advise:

- ▶ “The local authority rate is £530 per week, but for the care home you have chosen, you will pay ‘top-up’ fees of £100 per week. In return for a one-off premium of £7,000, you can uprate the ‘cap’ to cover all of your care fees when you reach the ‘cap’, including your ‘top-up’ fees. However, by this stage you will already have spent more than £72,000.”

Pros:

- ▶ By recognising that the ‘capped cost’ reforms do not cap private expenditure on care, ‘top-up INAs’ would help councils, care providers and the government address this issue in relation to public expectations.

Cons:

- ▶ Variations among different care users in how much they have to pay for a top-up INA may strike some as unfair.

In addition to overseeing and advising on the availability of such ‘top-up INAs’, there are several additional ways in which the government could build top-up INAs into the ‘capped cost’ offer from local authorities to provide greater certainty to individuals.

10.11 Option 6: Build top-up INAs into the ‘capped cost’ offer: ‘capped premiums’

INAs are ‘individually underwritten’, i.e. insurers undertake an assessment of an individual person’s medical history, condition and other factors in order to estimate their life expectancy upon going into residential care, and calculate their premium on that basis. This means that for a weekly income of, for example, £400 per week, one person might pay a one-off premium of £75,000 and another might pay £100,000, because of differences in their characteristics and life expectancy.

Such variations would also apply to top-up INAs that paid out smaller amounts such as £100 per week.

In order to provide greater certainty to individuals planning ahead or moving into residential care, local authorities could ‘cap’ the premium that individuals have to pay for a top-up INA. For example, a council could publish standard capped premiums for ‘top-up’ INAs as follows:

- ▶ “Worthenshaw Council standard-rate rate for residential care is £530 per week. If you pay ‘top-up’ fees in addition to this amount, you have the option of purchasing a ‘top-up annuity’, which will pay your ‘top-up’ fees for the rest of your life.

The cost of the premiums for a top-up annuity is capped by Worthenshaw Council as follows:

For a weekly top-up income of...	You will not pay a premium more than...
£100	£20,000
£150	£25,000
£200	£30,000
£250	£40,000

10.12 Option 7: Build INAs into the ‘capped cost’ offer: ‘capped premiums’ and ‘star ratings’

Although the availability of top-up INAs with capped premiums would enhance the options to self-funders in the wake of the ‘capped cost’ reforms and the protection provided, most individuals have little knowledge of how much residential care costs, and in particular, what an additional £100 per week would actually mean in terms of the service received.

In this context, there may be a compelling case for local authorities to monitor the different fees charged by different providers for different standards of care home – e.g. 3*, 4*, 5* - and on this basis, publish the typical, capped premiums that individuals would have to pay for a top-up INA:

- ▶ “Worthenshaw Council will pay for 3* rated residential care. If you move into a 3* home, your care costs will be capped at £72,000. However, if you move into a 4* or 5* home, your fees may be more expensive and you will have to pay top-up fees. In this situation, you will be able to purchase an immediate needs annuity for the cost of your top-up fees, beyond which your remaining care costs will be capped at £72,000.

The cost of the premiums for a top-up INA is capped by Worthenshaw Council as follows:

If you move into a...	You will no more than...
3* care home	£72,000
4* care home	£72,000 plus a one-off top-up immediate needs annuity of £20,000
5* care home	£72,000 plus a one-off top-up immediate needs annuity of £30,000

10.13 Conclusion

This chapter has explored why the ‘capped cost’ reforms to care funding in England will fail in their central purported aim of capping private expenditure on care.

To address this issue, the government could:

- ▶ Scale down claims for the reforms that they will cap people’s care costs;
- ▶ Intervene in care markets to close the gap between local authority ‘usual cost’ rates and average self-funder fees;
- ▶ Explicitly distinguish that local authorities pay less for care than private individuals, and on that basis promote and offer to individuals the opportunity to use ‘top-up’ INAs to effectively uprate their ‘cap’ in return for a one-off premium.

Part 6: Toward the ‘capped cost plus’ model

11. Bringing the Options Together: ‘Capped cost plus’

Bringing together the options identified in this report, what would an alternative ‘capped cost’ reform to care funding in England look like that could be implemented in 2016?

11.1 The ‘capped cost’ model, the ‘perception gap’ and the case for a change of plan

The analysis presented in this report suggests there are compelling reasons to think that none of the benefits of the ‘capped cost’ reforms set out by the government will be achieved, and that a change of plan is therefore essential.

- ▶ “For the first time, from April 2016, people will have more certainty on how much they should have to pay for care.”

No one will have certainty over how much they will have to pay for their care. Individuals will frequently have to spend down their wealth by more than £72,000 before they reach the ‘cap’, and will continue confronting care costs beyond it.

- ▶ “People will no longer face the prospect of potentially unlimited care costs.”

Everyone will continue to face the prospect of potentially unlimited care costs except in so far, as now, that they spend down their wealth to the ‘Lower Capital Limit’.

- ▶ “Those who can afford to pay for their care will be more able to proactively plan and make provision to access the kind of care and support they would want in later life.”

With no prospect of pre-funded insurance products in relation to the £72,000 ‘liability’, or more widely, it will be impossible for individuals to proactively plan ahead by insuring themselves. As now, the principal option for those wanting to prepare for the costs of care will be to save. However, given the annual increases in the ‘cap’ to take account of inflation – beginning at around £3,000 per year - exceeds the amount that most households save each year, the operation of the ‘capped cost’ reforms may in fact demotivate most individuals from savings specifically against care costs.

- ▶ “Everyone will have this reassurance, not just the 16% of older people who need care who face care costs of £72,000 or more.”

No one in the population will have reassurance that their care costs will be capped.

11.2 The options for policymakers

This report has examined multiple issues and challenges to the government's 'capped cost' reforms to care funding in England, which are due to be implemented in 2016.

These issues, and the options identified for policymakers, can be summarised as follows:

The issue	The options
"Councils are struggling to implement the reforms"	1: Implement the 'capped cost' reforms in stages 2: Enable councils to implement the reforms at a time of their choosing
"The reforms are making it harder to integrate health and social care"	1: Withdraw home care from the 'capped cost' reforms and develop new ways to apply the 'capped cost' principle coherent with integrated care
"People can't buy insurance against the £72,000 liability"	1: Enable individuals to 'buy' a lower 'cap' through a charge on their estate
"The cap is scaring and confusing people"	1: Adopt alternative measures of care costs 2: Introduce an additional, static 'years of care' cut-off period
"The 'cap' does not cap 'Moderate' need care costs"	1: Lower the threshold of qualifying needs under the 'capped cost' reforms from Substantial to Moderate. 2: Extend entitlement to means tested support to Low and Moderate needs, but retain the threshold for 'metered' expenditure at Substantial
"The reforms are encouraging families to play the system"	1: Replace purely notional Personal Budgets with low-level co-payments 2: Narrow the Upper and Lower Capital Limits
"Few at the 'Upper Capital Limit' are receiving support from their council"	1: Index the Upper Capital Limit to what councils pay for residential care in England 2: Raise the Lower Capital Limit 3: Change the ratio used to calculate 'tariff income'
"The 'cap' isn't capping care costs"	1: Change the language around the 'capped cost' model 2: Clarify 'council-rate' fees 3: Intervene in care markets to align 'council-rate' fee levels with prices for self-funders 4: Clarify the 'council rate' in terms of quality 5: Extend options for asset protection by building 'top-up' immediate needs annuities into the 'capped cost' reforms 6: Build top-up INAs into the 'capped cost' offer with 'capped premiums' 7: Build INAs into the 'capped cost' offer with 'capped premiums' and 'star ratings'

11.3 Building the ‘capped cost plus’ model

From the options for policymakers identified above, it is possible to assemble a new, ‘**capped cost plus**’ model of long-term care funding reform in England.

For home care:

- ▶ Capped integrated home care costs via a weekly cap on charges of £100 per week.

Why? Withdrawing home care from the ‘capped cost’ model will enable the continued integration of health and social care in England. It will give local government and the NHS the flexibility required to implement new models of health and social care funding, commissioning and provision. A weekly cap on means tested charges, uprated over time with inflation, will provide clarity and peace of mind, and protect individuals from catastrophic care costs.

For residential care:

- ▶ Introduce an additional ‘years of care’ cut-off period alongside the £72,000 ‘cap’

Why? The existing ‘cap’ on residential care proposed for 2016 of £72,000 will potentially create confusion and fear. An additional ‘years of care’ cut-off period, set at around five years, will be the same across the country and over time, providing a consistent point of reassurance to households.

- ▶ A single Capital Limit for residential care of £70,000

Why? Variations in the ‘usual cost’ rate by councils, and the additional incentive to engage in deliberate deprivation among families, undermines the rationale for an Upper Capital Limit of £118,000 in 2016. Although representing a ‘cliff-edge’ in entitlement, a single Capital Limit of around £70,000 will provide greater simplicity and clarity.

- ▶ Build top-up INAs into the ‘capped cost’ offer with ‘capped premiums’

Why? Differences between the prices paid for residential care by local authorities and self-funders are inevitable, but pose a fundamental challenge to the ‘capped cost’ reforms. By guaranteeing that self-funders can access a ‘top-up INA’ priced at a fair, ‘community-risk’ rated level, the ‘capped cost plus’ model will offer transparency and greater certainty to self-funders.

- ▶ Enable individuals to buy a lower ‘cap’ through a charge on their estate

Why? Individuals should be able to protect themselves from the liability they are left with for residential care costs under the 2016 reforms. Since the private sector will be unable to offer such protection, the state must step in and make this available instead. Enabling pre-commitment to an optional charge, paid from estates and uprated annually with inflation, will ensure cost-neutrality for the Exchequer, but give those who choose it access to a £0 ‘cap’.

11.4 Treating home and residential care differently

A notable feature of this ‘capped cost plus’ model, in contrast to the ‘capped cost’ model, is that it treats home and residential care differently, which could be viewed as inconsistent and unfair.

However, in the context of a health and care system that combines ‘free at the point of use’ and means tested services, inconsistent rules on charging and means testing are inevitable, and a necessary price if policymakers wish to enable the full integration of health and social care funding, commissioning and provision in England.

11.5 ‘Capped cost plus’: What will it look like to users?

▶ Before needing care

“If I receive care in my home, I won’t be charged more than £100 per week. If I move into a care home, I am guaranteed to receive support for at least ‘council-rate’ care’ after five years, no matter where I live or when I move into residential care. If I want to have access to non-means tested care in future, I have the option of paying an estate charge.”

▶ Upon receiving home care

“I am not paying more than £100 per week for integrated health and care services in my home.”

▶ Upon moving to residential care

“I am paying more than the council-rate for residential care in my area. However, my local authority has given me the option to pay a ‘top-up’ premium, which will mean that all of my care costs are taken care of for the rest of my life once I reach the ‘cap’.

11.6 Conclusion

The 2016 ‘capped cost’ reforms to care funding in England are not going to meet any of their objectives, and fall short of the government’s claims for them.

By deploying some of the options identified in this report, it is possible to assemble an alternative ‘capped cost plus’ model, which solves many of the issues for the original ‘capped cost’ model, and would go much further in meeting the government’s objectives for the reforms.

Appendices

Appendix 1: The ‘capped cost’ principle

This section explores why it is the responsibility of the state to protect people from catastrophic care costs

Why do people require paid care?

Individuals may require care and support because they experience physical or cognitive impairments that make it difficult for them to undertake ‘activities of everyday living’. These activities may comprise getting out of bed, getting dressed, washing and bathing, making a meal, etc. Physical and cognitive impairments may result from specific long-term health conditions, or may simply be associated with the ageing process.

Most care and support is provided as ‘informal care’ by partners and other family members. However, some individuals also receive paid care in their home or in a residential care facility, in addition or in lieu of, informal care.

Why do individuals require paid care?

Individuals may receive paid care rather than informal care because it is their preference, or because family members are not able to provide it. This may be because family members:

- ▶ Live far away;
- ▶ Have other employment or caring obligations;
- ▶ Need to engage in paid employment – i.e. they cannot afford to provide informal care;
- ▶ Would not be able to provide the volume or type of care and support a person requires;
- ▶ Have provided care but are no longer able to do so;
- ▶ Respect the wishes of the person needing care to receive it from paid, professional carers.

How is the price of social care determined?

The majority of paid care provision is undertaken by charities and private companies, paid for by local authorities, care users, the families of care users, or a combination of these sources. The price of both care in the home and care in a residential care facility is determined by supply and demand in the marketplace.

What determines the cost of social care to individuals?

As in other markets, the unit cost of home care and residential care to individuals funding their care themselves depends on what individuals are willing to pay, and what providers are willing to supply for different prices.

How do individuals – rather than the state - come to pay for care themselves?

The state-funded local authority social care system in England rations financial support for care costs on the basis of a person's financial means (income and wealth) and level of need. Across England, there are:

- ▶ 532,000 older people and 350,000 working-age people receiving local authority funded home care;
- ▶ 325,000 older people funding their own home care;
- ▶ 170,000 local authority supported older people in residential care, and 54,000 local authority supported working age adults;
- ▶ 125,000 older people funding their own residential care.²²

Individuals pay for care themselves – rather than their local authority – for one of several reasons:

- ▶ They have not sought an assessment of entitlement to support from their local authority because, for example, they are not aware they may be entitled to support;
- ▶ Following an assessment of need, their local authority judges that a person does not meet their 'eligibility threshold' of need, either because their level of disability is too low, or because they are able to rely on family members to provide informal care;
- ▶ Following an assessment of a person's financial means, their local authority judges they are above the pre-defined means test threshold because of their income, savings or – for those in residential care – property wealth.

Importantly, there are differences between what individuals and local authorities pay for care, in particular, residential care. The maximum amount a local authority will usually be prepared to pay for residential care is called the 'usual cost' rate. This rate varies by local authority, and for different levels and types of care home. However, in theory, the amounts should be sufficient to allow a local authority to meet a person's assessed care needs in a residential setting.

In its 2012-13 analysis of the residential care market, the market research company Laing & Buisson found the average English council pays £480 per week for a residential care place (excluding nursing residential care), which is around £50-140 per week less than what Laing & Buisson calculate as the 'fair market price'. This suggests 'self-funders' pay at least £85 per week more than the local authority 'usual cost' rate for a place in residential care.²³

What determines the financial support that individuals receive from their local authority?

Local authorities apply a means test and set of rules on 'assessable wealth' to determine what support individuals receive. There are two so-called 'capital limits' of £14,250 and £23,250.

Any individual with more than £23,250 in 'assessable wealth' will receive no financial support from a local authority for their care needs. For care in a person's home, 'assessable wealth' includes liquid savings, ISAs, etc. However, if a person moves into residential care and no

close relative (i.e. a partner or child) is living there, the value of a person's home also qualifies as 'assessable wealth'. In this situation, the vast majority of homeowners who leave behind an empty home upon entering residential care immediately find they are above their local authority's means test threshold.

Individuals with less than £14,250 in 'assessable wealth' are entitled to have all of their care costs paid for by their local authority, but are expected to contribute their full income, minus a 'Personal Expenditure Allowance' of £23.50 per week.

Individuals with 'assessable capital' between £14,250 and £23,250 are expected to contribute 'tariff income', which is calculated as £1 per week for every £250 of capital. So, for example, someone with £20,000 of wealth would be charged a tariff income on the £5,750 of their wealth that is 'assessable wealth' capital, which amounts to £23 per week.

What are 'catastrophic costs'?

No formal definition of 'catastrophic costs' exists. Nevertheless, it is commonly used to refer to accumulated private expenditure on care that uses up all, or a large proportion of, a person's wealth and is relative to a person's wealth before they needed care. Put more simply, catastrophic costs occur when individuals are forced to spend down most of their wealth to meet their care costs.

Catastrophic costs are most commonly experienced by the 125,000 'self-funders' in residential care, for which the weekly cost can be anything between £350 and £2,000. Over an extended period in residential care – for example, three years or more – those funding this care themselves can confront very high accumulated care bills: 'catastrophic costs'.

The following table shows the average probability of going into residential care among those reaching retirement age, as well as the average length of stay across the whole population, as well as among the group who do go into residential care:²⁴

Estimates of expected lifetime LOS in care homes at age 65 assuming higher mortality for all care home residents

	Men	Women	Total
Probability of going into residential care	19%	34%	27%
Estimated average length of stay (all)	32 weeks	89 weeks	64 weeks
Estimated average length of stay (entrants only)	171 weeks	262 weeks	235 weeks

Hancock R and Morciano M (2013)

It is important to underline that the rate at which 'self-funders' in residential care spend down their wealth depends on two factors:

- ▶ The cost of their residential care;
- ▶ Their total income - potentially comprising State Pension, disability benefits and private pension income – which they can use to meet part of their care fees.

For example, imagine 'Mrs Smith' enters a residential care home costing £650 per week, has £200,000 of assets and total income of £250 per week, comprising £107.45 State Pension and £142.55 of private pension income.

Assuming that Mrs Smith directs all of her £250 per week income toward her £650 per week care fees, Mrs Smith will therefore spend down her assets at a rate of £400 per week, or £20,800 per year.

However, if Mrs Smith's income had been higher – for example, £350 per week – she would only have had to spend down her wealth at a rate of £300 per week.

Why is it the role of the state to protect people from catastrophic care costs?

The principle that it is the responsibility of the state to provide protection to individuals from catastrophic care costs rests on an observation about the nature of risk and uncertainty in relation to social care.

Considered at a societal level, two principal forms of risk pooling exist in society outside of the 'family unit':

- ▶ Private insurance – individuals buy insurance against any number of potential adverse events such as theft, destruction of their home by fire, etc.;
- ▶ The state – the social security system and the NHS provide financial support and services to individuals who experience certain adverse events, such as unemployment, ill health, etc.

In relation to care costs, private insurance companies cannot offer 'pre-funded' insurance against catastrophic care costs because of the difficulties they have 'pricing' these risks. Insurance companies are unable to accurately forecast what proportion of the population will need care in the future and for how long. Put another way, it is almost impossible for insurers to anticipate who will experience high levels of disability and – in particular – for how long they will experience it.

To cover themselves in the face of this uncertainty, insurers have previously had to impose high charges for pre-funded care insurance products – making them unaffordable to the public – or to impose defined limits on how much a policy will pay out, thereby leaving individuals exposed to the risk of catastrophic care costs.

Private insurance companies cannot therefore offer protection from catastrophic care costs. On this basis - it is argued - it is responsibility of the state to provide protection to individuals from catastrophic care costs.

Are there different ways to measure catastrophic costs besides private expenditure on care?

Yes. Private choices about when to spend on care and how much are subjective decisions. However, other subjective and objective measures could be used to define catastrophic costs, relating to expenditure, need and disability.

As well as private expenditure, a second subjective measure is local authority decisions on how much financial support for care costs they would assess a person as requiring. This is the subjective measure used for 'metering' an individual's notional, assessed care costs under the 'capped cost' model.

In relation to 'objective' measures of catastrophic costs, two ways of measuring catastrophic costs include:

- ▶ Length of disability – length of time that someone has experienced an objective level of disability, such as two years of experiencing three 'Activity of Daily Living' (ADL) failures;
- ▶ Accumulated experience of disability – an approach that records accumulated 'units' of disability through measuring different levels of disability that individuals experience and the length of time they experience this disability for.

Appendix 2: The context for reform

This section examines the ‘capped cost’ model in detail, and the wider context for reform.

The government’s decision to implement the ‘capped cost’ reforms from April 2016 has taken place in the context of enormous pressures, change and reorganisation across the health and care system in England, as well as a challenging fiscal outlook.

First and foremost, these pressures are budgetary:

- ▶ Resource pressures on the baseline care system in England;
- ▶ Rising demand for care owing to population ageing;
- ▶ Funding pressures on the NHS;
- ▶ Challenging fiscal outlook for public spending.

In addition, the implementation of reforms to care funding in England must take place against wider systemic changes in the health and care system:

- ▶ Adult Social Care Outcomes Framework;
- ▶ The Care and Support Bill;
- ▶ Reorganisation of the NHS;
- ▶ Integration of health and social care.

This chapter explores these issues in more detail.

11.7 Resource pressures on the baseline care system in England

In its 2013 survey of members, the Association of Directors of Adult Social Services (ADASS) found that local authority expenditure on adult social care had been reduced by £2.68 billion in the preceding three years, including £800 million in the 12 months to April 2013.²⁵ The survey found that at least 13% of these reductions resulted from the withdrawal of services.

The implementation of the ‘capped cost’ model must therefore take place in the context of intense pressures on local authority social care expenditure.

11.8 Rising demand for care owing to population ageing

Population ageing will see rising levels of disability across the population, and growing demand for care and support. This means that just to ‘stand still’ – i.e. maintain equivalent levels of support - public spending on care and support in England will have to increase.

Analysis by the Personal Social Services Research Unit (PSSRU)²⁶ for the Nuffield Trust projects that in England:

- ▶ The number of older people with moderate or severe disabilities is projected to increase by 32%, and public expenditure on social care and continuing health care for older people by 37% between 2010 and 2022, assuming that current patterns of care and the ONS principal population projections keep pace with expected demographic and unit cost pressures;
- ▶ Net public expenditure on social care and continuing health care for older people is projected to rise from £9.3 billion in real terms (0.74% of GDP) in 2010 to £12.7 billion (0.78% of GDP) in 2022, assuming that current patterns of care and the ONS principal population projections keep pace with expected demographic and unit cost pressures;
- ▶ Local authority public expenditure on social services for older people (net of user charges) is projected to rise, under the current funding system and patterns of care, from around £7.3 billion in 2010, to £9.8 billion in 2022 in constant 2010 prices.

Wittenburg R et al. (2012) Care for older people - projected expenditure to 2022 on social care and continuing health care

11.9 Funding pressures on the NHS

Projections published by the Nuffield Trust (2012) suggest that:²⁷

- ▶ Budgetary pressures on the NHS will grow at around 4% a year up to 2021-22;
- ▶ If NHS funding is held flat in real terms beyond the current Spending Review period, the NHS in England could experience a funding gap worth between £44 and £54 billion in 2021-22, unless offsetting productivity gains can be delivered.

As the Trust observes, the current 'Quality, Innovation, Productivity and Prevention (QIPP) Challenge' undertaken by the NHS sought productivity gains of around 4% a year to 2014-15, and if this is achieved, the Trust projects that the funding gap of £44 to £54 billion will be reduced to a potential shortfall of £28 to £34 billion by 2021-22.

With workforce costs comprising such a large proportion of NHS expenditure, the Trust expects restraint in pay settlements to contribute around 40% of required QIPP savings by 2014-15. However, beyond this point:

"If NHS earnings start to increase in line with the historic increase of two per cent a year above inflation, greater savings will need to be made in other areas."

(Roberts A et al.: 2012)

Overall, the financial situation facing the NHS over the coming decade is by far the most challenging it has ever experienced.

11.10 Challenging fiscal outlook for public spending

In its 2013 'Fiscal Sustainability Report', the Office for Budget Responsibility reported that:²⁸

- ▶ In March 2013, public sector net debt (PSND) – the difference between the public sector's liabilities and its liquid financial assets £1,181 billion - was 75.1% of GDP;
- ▶ The medium-term outlook for PSND had deteriorated since the previous year's report, and the expected medium-term peak in PSND had risen by 9.3% of GDP to 85.6 per cent of GDP, with that peak coming two years later in 2016-17.

Conclusion: The resource challenge

This review of the resource challenge facing reform to protect individuals from catastrophic care costs suggest several conclusions:

- ▶ Funding for the reform of care funding will be in competition for resources with the NHS, and the government's deficit reduction programme;
- ▶ Without additional funding for the baseline social care system in England, local authorities may direct resources made available for the 'capped cost' model to the current baseline system;
- ▶ Confronting a dire funding outlook, the NHS may seek to shift some of its costs on to local authorities, particularly health and care budgets are to be more closely aligned.

11.11 Adult Social Care Outcomes Framework

In recent years the government has sought to clarify what outcomes different agents – particularly local authorities - in the social care system should seek to achieve in the form of measurable, comparable outcomes. These have now been collated in the form of the Adult Social Care Outcomes Framework (ASCOF), published by the Department of Health (DH).²⁹ The stated purpose of the ASCOF is:

- ▶ To support councils to improve the quality of care and support through robust, nationally comparable information on the outcomes and experiences of local people;
- ▶ To foster greater transparency in the delivery of adult social care, supporting local people to hold their council to account for the quality of the services they provide;
- ▶ To measure – at a national level - the performance of the adult social care system as a whole, and its success in delivering high quality, personalised care and support.

Although still representing a 'work in progress', the most recent ASCOF published by DH groups the outcomes of interest in four domains:

- ▶ Enhancing quality of life for people with care and support needs;
- ▶ Delaying and reducing the need for care and support;
- ▶ Ensuring that people have a positive experience of care and support;
- ▶ Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.

The significance of ASCOF is in clarifying and embedding key measurable outcomes that the social care system will have to achieve alongside - in future – providing greater protection to individuals from catastrophic costs.

However, the implementation of the ASCOF will impose pressures on the resources and the capacity of local authorities, as well as care providers.

11.12 The Care and Support Bill

The draft Care and Support Bill was presented to Parliament by the Secretary of State for Health in July 2012.³⁰ The Bill represents an historic attempt to clarify what social care is, what it is for, and the responsibilities of local authorities toward individuals with a disability.

The first clause of the draft Bill seeks to set the context for all that follow: the wellbeing of the individual is paramount and local authorities must promote the individual's wellbeing in decisions made with and about them.

The draft Bill puts forward a number of general duties on local authorities applying at the population-level, relating to:

- ▶ Information and advice;
- ▶ The universal availability of 'deferred payment schemes';
- ▶ Market-shaping;
- ▶ Integration; and
- ▶ Prevention.

The Care and Support Bill provides a single duty for councils regarding when, how and for what purpose they must undertake needs assessments. In particular, such assessments:

- ▶ Must be of the adult's needs and the outcomes they want to achieve;
- ▶ Must be provided to all people who appear to have some need, without consideration of their finances or whether they will meet the eligibility threshold;
- ▶ Must be carried out with involvement from the adult and their carer.

These changes to the legal basis for local authority needs assessments will operate in tandem with changes in the entitlement of individuals, from an entitlement to 'services' to an entitlement to 'having needs met'.

The passage of the Care and Support Bill is likely to take place ahead of the launch of the 'capped cost' model in 2016, and local authorities will have to implement and apply the various clauses in the Bill at the same time as protecting individuals from catastrophic care costs. In this context, local authorities will confront a number of challenges relating to both the additional cost of ensuring they meet in full the provisions in the Bill, and potential increases in demand arising from clauses in the Bill. In particular:

- ▶ Implementation costs – the Department of Health has already estimated that the cost of implementing the 2012 social care White Paper and the Care and Support Bill as £1.93 billion up to 2022 (2010 prices);
- ▶ Potential 'demand effects' – stronger duties to inform individuals of their right to an assessment may result in more individuals coming forward who meet the local authority needs threshold. However, in the absence of definitive data on 'self-funders' hidden from the local authority care system, this is hard to quantify;
- ▶ Monitoring – strengthened rights in the Bill for people to opt to receive their entitlement to support as a Direct Payment may have implications for how councils monitor use of resources;

- ▶ Supply of informal care – stronger rights to assessments and support services by family carers may result in carers reducing the volume of support they provide, with consequent implications for the amount of paid support that local authorities must fund for people with eligible needs.

Overall, reform of care funding to protect individuals from catastrophic care costs, the introduction of a national eligibility threshold and the Care and Support Bill represent, as the Joint Committee on the Care and Support Bill note, “a significant implementation challenge for everyone with a stake in the care and support system.”³¹

11.13 Reorganisation of the NHS

The 2012 Health and Social Care Act initiated unprecedented changes in the structure and organisation of the NHS, which were implemented in April 2013. The principal aims of the Act can be summarised as follows:

- ▶ Under the oversight of the NHS Commissioning Board, GP-led clinical commissioning groups to directly commission health services for their local populations;
- ▶ To make it significantly easier for private and charity health providers to be commissioned to provide health services alongside NHS providers, who in turn will be able to take on a much higher proportion of private work;
- ▶ For new Health and Wellbeing Boards to bring together local commissioners of health and social care, elected representatives and representatives of ‘Healthwatch’ (a new consumer champion for health and social care in England) to decide on joint commissioning strategies for health and wellbeing in the local area.

CCGs have been created in order to be able to commission services from foundation trusts, the charitable and private sectors. A clear and specific aim of the government is to introduce diversity in provision, i.e. for there to be more organisations providing different types of services in an area. The creation of CCG commissioning may represent a challenge to implementation of the ‘capped cost’ model. As the proportion of health services provided by the independent sector grows before and after 2016, this creates significant potential risks for:

- ▶ Coordination failures – the rotation of providers in both health and social care provision may lead to coordination failures, for example, lost data, contact details, etc.;
- ▶ Cooperation and relationships – effective joint working between health and social care professionals requires cooperation and effective relationships involving trust and communication, but this may be adversely affected by a greater plurality of providers;
- ▶ Cost-shifting – existing social care providers and NHS health providers are incentivized to shift costs and responsibilities to each other in providing support to someone in the care system. The replacement of NHS health services in this context by a greater plurality and diversity of independent providers may result in an increase in cost shifting.

The implementation of Health and Wellbeing Boards may pose a challenge to other reforms to the care system, further increasing the workload for local authorities. Health and Wellbeing Boards are designed to introduce local flexibility that actually triumphs local differences and variation with other areas, including in relation to what are care needs, what local assets can

be used to meet need, and the support that is available to individuals with different levels of need to address them.

On the one hand, this is potentially incoherent with aims of predictability in entitlement to home care, and ultimately to some of the aims of the Care and Support Bill regarding clarity around entitlement. However, a principal aim of Health and Wellbeing Boards is to positively disrupt what is currently delineated as social versus health care and need in a local area, make use of ‘assets’ in the community, and provide services to individuals not currently receiving them in order to prevent subsequent demand.

All of these aims have profound implications for any reform of long-term care funding policy around protecting individuals from catastrophic costs that is based on standardised ‘metering’ of notional care costs. For example, if a local authority were actively measuring assessable care needs among all those with eligible needs in the community, the authority’s definition of care needs and who receives council support may be in tension with the aims of the Health and Wellbeing Board.

11.14 Integration of health and social care

Both the Health and Social Care Act and the draft Care and Support Bill contain provisions related to encouraging the integration of health and social care:

- ▶ Health and Wellbeing Boards and CCGs have a duty to encourage integrated working of commissioners and providers in order to improve the health and wellbeing of the local population, reduce inequalities, and improve the quality and experience of services for the local population;
- ▶ The Care and Support Bill stipulates that local authorities must co-operate with other local organisations and work to integrate services.

Significant interest in advancing integrated care funding via pooled budgets to enable joint commissioning of health and care is also observable at a political level, notably:

- ▶ Joint commissioning of health, care and housing via pooled budgets was the principal recommendation of a 2012 inquiry into social care by the cross-party Parliamentary Health Committee;
- ▶ The Shadow Secretary of State for Health has called for ‘whole person’ care as part of how NHS and social care services respond to the demand and service design pressures of an ageing population.³²

Most significantly, in the 2013 Spending Round announcement, HM Treasury announced that for 2015-16, it would put:³³

“£3.8 billion in a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities. This shared pot includes an additional £2 billion from the NHS and builds on the existing contribution of around £1 billion in 2014-15, with the aim of delivering better, more joined-up services to older and disabled people, to keep them out of hospital and to avoid long hospital stays.”

Source: HM Treasury (2013)

Appendix 3: “Rules on living costs and benefits are unfair”

Rules on ‘living cost’ contributions and receipt of Attendance Allowance need significant further work and clarification.

What’s the issue?

Under the ‘capped cost’ reforms, some individuals will have to spend down their assets to fund their ‘living costs’ in residential care.

Background

The Commission on Funding of Care and Support recommended that individuals should be expected to make a standardised contribution to ‘living costs’ in residential care, given it was reasonable to expect everyone to save for and fund their basic living costs in retirement. The Commission recommended the level of this contribution should be set between the value of the State Pension and the median income of older people.

In practice, this means that the first £230 of people’s care home fees will always and everywhere be treated as ‘living costs’, rather than ‘care costs’, and will not be ‘metered’ as a care cost that counts toward a person’s Care Account.

However, it is important to note that despite being called ‘living costs’, this amount is not based on actual living costs for people in residential care, which is a value that is extremely difficult for care providers to determine in practice. Instead, the £230 level is simply the estimated median income of pensioners in England in 2010.

Inevitably, by setting the level of expected contribution toward ‘living costs’ as median income among pensioners, half of the pensioner population will have incomes below this. In fact, among individuals in residential care, the median income among this group may be substantially lower given people in the oldest age groups, and care users, often have lower incomes overall.

However, because the expected Living Cost contribution has been set at this relatively high level under the ‘capped cost’ reforms, some individuals with a lower income will inevitably have to contribute their ‘living cost’ contribution from their wealth.

What are the implications of setting the ‘living cost’ contribution at this level? Self-funders in residential care with an income below £230 per week will have to spend down their wealth on their care fees in order to fund their notional ‘living costs’, even though such wealth depletion resulting from paying their care fees will not be reflected in the metering of their care costs, or Care Account.

In this way, the design of the 'capped cost' reforms the government has undertaken to implement in April 2016 will not protect the wealth of lower-income individuals.

Vignette

Mrs Smith moves into residential care aged 85 in April 2016. She has assets totalling £250,000 (including the value of her home, which is subsequently sold) and a total income of £160 per week.

She pays £650 per week for her place in a standard care home, using all of her income on her care fees, and therefore spending down her assets at a rate of £490 per week to cover the difference.

Her local authority's 'usual cost' benchmark rate for residential care is £550 per week. This is the most her local authority will pay for a place in residential care. So, Mrs Smith's 'meter' only increases by this amount minus her notional £230 per week 'living cost' contribution, i.e. by £320 per week.

In other words, £320 is the weekly progress she makes toward the £72,000 'cap'.

So, through depleting her assets by £490 per week, Mrs Smith must not only pay for a 'top-up' over and above the local authority rate, but must also deplete her assets to fund what the local authority regards as her 'living costs'.

Why does this matter?

As described above, the 'top-ups' paid by ordinary self-funders in residential care already mean that self-funders will have to deplete capital in excess of £72,000.

However, by disregarding as an expected 'living cost' contribution the first £230 of a person's care fees, the extent of additional capital depletion will be even larger, undermining the central claim made of the 'capped cost' model, and affecting lower income individuals in particular.

What can policymakers do in response to this issue?

Option 1: Boost the incomes of those in residential care through Attendance Allowance

To ensure no one in residential care has to spend down their assets as a contribution to their 'living costs', the government could seek to ensure that everyone in residential care has an income of at least the level of the value of this contribution.

One option to do this would be to use the Attendance Allowance system. Most individuals in residential care would be expected to have support needs that would entitle them to receive Attendance Allowance (AA), which is a universal weekly cash benefit paid by the Department for Work and Pensions (DWP) to older people at two levels: £53 and £79.15. However, for reasons such as inertia or stigma, not everyone in residential care receives AA.

If it is assumed that in 2016, the DWP's 'Minimum Income Guarantee' for older people has been uprated to £160 per week, and AA to £59 and £88 per week, the government could be confident that all 'self-funders' in residential care receiving higher rate AA would be able to pay for their expected 'living cost' contribution to their care fees from income.

To ensure this was the case, the government could change eligibility rules for higher-rate AA such that all 125,000 self-funders in residential care in England would be guaranteed entitlement to higher-rate AA. The government could also implement measures to ensure self-funders in residential care make claims for AA.

Option 2: Reduce the level of the expected 'living cost' contribution

Rather than boosting the incomes of self-funders in residential care using the disability benefits system, the government could simply lower the expected 'living cost' contribution of self-funders in residential care, for example, to the level of the DWP's so-called 'Minimum Income Guarantee' for pensioners (currently around £145 per week) or, in future, the level of the Single-Tier State Pension.

What's the issue?

Individuals paying for their own residential care who receive Attendance Allowance – currently worth between £53 and £79.15 per week – may lose this once they begin receiving as little as £1 per week in council support.

Background

Under current rules, individuals in residential care who receive any financial support from their local authority for their care costs lose entitlement to receive Attendance Allowance.

Following April 2016, the Upper Capital Limit for residential care will be increased to £118,000. Although to become entitled to financial support, individuals may have to spend down their wealth significantly further. Nevertheless, beyond a certain point, individuals will become entitled to small amounts of support toward their residential care costs, for example, £5 per week.

However, upon receiving as little as £5 per week from their local authority, individuals in receipt of AA who fund their own care will lose entitlement to AA, meaning they could be significantly worse off overall.

Option 1: Change the rules on receipt of Attendance Allowance

To ensure individuals are not made worse off through receipt of means tested support for residential care costs from 2016, the government could:

- ▶ Enable self-funders to carry on receiving AA regardless of their receipt of means tested financial support;
- ▶ Change rules on means tested eligibility, such that individuals only receive means tested support for residential care costs when the value they would receive is higher than the

value of AA.

Conclusion

This appendix has identified that further work is required on rules around the 'living cost' contribution, AA and entitlement to local authority support. Ultimately, these issues are interlinked, because universal take-up of AA among self-funders in residential care to ensure all can afford their 'living cost' contribution from income would mean individuals would have to spend down their wealth substantially more in order for it to be in their financial interest to receive local authority support rather than AA.

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