Title:	Impact Assessment (IA)
Social Care Funding Reform Impact Assessment	**Date:** 08/04/2013
IA No: 9531	**Stage:** Final
Lead department or agency:	**Source of intervention:** Domestic
Department of Health	**Type of measure:** Primary legislation

Summary: Intervention and Options

Cost of Preferred (or more likely) Option

Total Net Present Value	Business Net Present Value	Net cost to business per year (EANCB on 2009 prices)	In scope of One-In, One-Out?	Measure qualifies as
£2.39bn	£0bn	£0bn	No	NA

What is the problem under consideration? Why is government intervention necessary?

Currently individuals face the risk of losing almost everything to pay for their care costs - ten percent of older people face care costs over £100,000. Most people are unable to protect themselves against these risks as the existing means tested support offers very little protection to those of moderate wealth and affordable financial products are unavailable.

The inability of people to protect themselves from these risks and maximise their wellbeing represents a market failure. Government intervention is therefore required to protect people from the risk of unlimited care costs.

What are the policy objectives and the intended effects?

The primary objective of the policy is to provide people with financial protection from catastrophic care costs and as a result give them the peace of mind from knowing that they do not risk losing all their assets to pay for their care. The policy should also help encourage people to take responsibility and plan and prepare for their care needs in later life, whilst helping ensure that the system is financially and politically sustainable and that it supports the wider government objectives for the care and support system including encouraging planning and prevention.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Extensive policy options were considered by the Commission on Funding Care and Support. The Government accepted the principles of their recommendation of a cap on care costs in July 2012. The analysis included within this impact assessment focuses on the Commission's proposed system of a capped cost model with an extended means test for residential care.

Will the policy be reviewed? Yes					
Does implementation go beyond minimum EU requirements?			N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** No	**< 20** No	**Small** No	**Medium** No	**Large** No
What is the CO$_2$ equivalent change in greenhouse gas emissions? (Million tonnes CO$_2$ equivalent)			**Traded:** 0		**Non-traded:** 0

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible Minister :   Norman Lamb MP   Date: 15 April 2013

Summary: Analysis & Evidence

Policy Option 1

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year :10/11	PV Base Year:16/17	Time Period Years: 10	Net Benefit (Present Value (PV)) (£bn)		
			Low: Optional	**High:** Optional	**Best Estimate: 2.39**

COSTS (£bn)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	0		Optional	**Optional**
High	0		Optional	**Optional**
Best Estimate	0		1.50	**12.37**

Description and scale of key monetised costs by 'main affected groups'

All the costs listed below fall upon the government and will be fully funded.
Cost of the cap and extended means test for older people (NPV £9.98 bn)
Cost of a lower cap for people who develop care needs at working age and free care for those with an eligible care need when they turn 18 (NPV £2.40 bn)
Cost of additional assessments, care managements and reviews (NPV £2.05 bn) – this represents an upper limit for these costs
Reduction in the costs of Attendance Allowance and Disability Living Allowance (NPV -£2.06 bn)

Other key non-monetised costs by 'main affected groups'

Transitional administration costs of implementing the scheme. These fall on the government and depend upon the details of implementation. The Department of Health will work with local authorities to better understand and mitigate these costs through its engagement and subsequent consultation over the summer.

BENEFITS (£bn)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	0		1.80	**14.76**

Description and scale of key monetised benefits by 'main affected groups'

Peace of mind to everyone from knowing that they will not face unlimited care costs.
Financial benefits to individuals receiving state support.
Net value of these benefits (minus the lost benefits from Attendance allowance and Disability Living Allowance) is £14.76 billion accruing to private individuals.

Other key non-monetised benefits by 'main affected groups'

People planning and preparing for their care needs in later life.
Space for financial services products that enable people to further mitigate their risks and gain additional peace of mind benefits.
Wider benefits from supporting other objectives for the care and support system including supporting preventative services and the provision of information and advice.

Key assumptions/sensitivities/risks	**Discount rate (%)**	3.5%

Impact on demand for formal care follows the projections produced by PSSRU.
Proportion of self funders who meet LA eligibility criteria.
Care costs (and the cap) rise in line with long term care cost inflation projections of two percent per year in real terms.

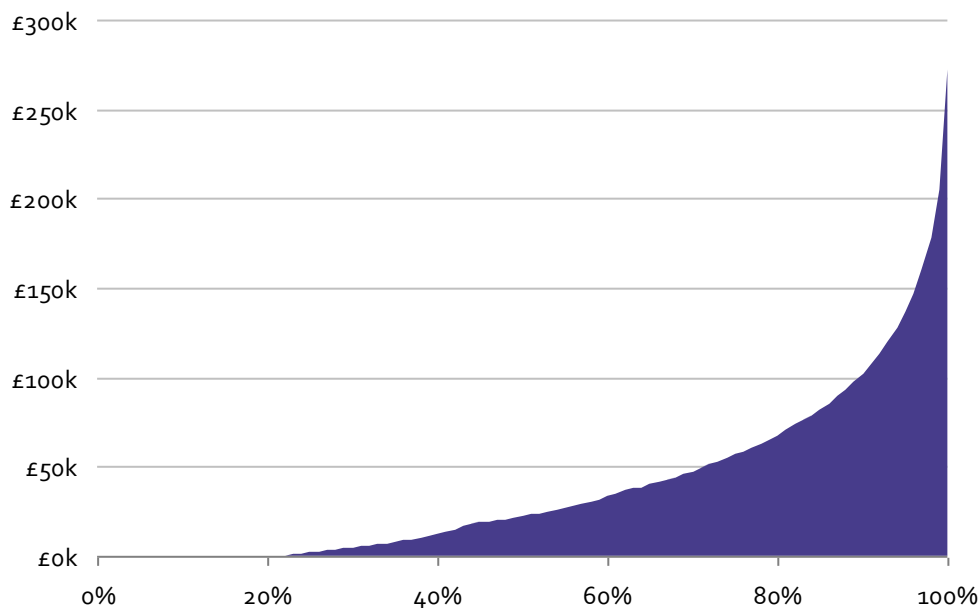**BUSINESS ASSESSMENT (Option 1)**

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: 0	**Benefits:** 0	**Net:** 0	No	NA

Evidence Base (for summary sheets)

Background – The case for change

1. One of the key problems with the current system is that people face the risk of very high and unpredictable high care costs, which they cannot protect themselves against. The report by the Commission on the Funding of Care and Support[1] and Caring for our Future: progress report on funding reform[2], set out in detail how catastrophic care costs create difficulties for people receiving care and support.

2. Those who pay the most are likely to be those with long-term chronic disabilities such as dementia, which mean that they need care and support for a long period, whilst those without significant care needs spend very little, if anything, on care. People are unable to predict whether they will face catastrophic care costs. People feel that it is unfair that if they have budgeted carefully through their working life, they are penalised because they receive little or no help.

3. People with low levels of savings currently have their care paid for by the state; but those who have assets worth above £23,250 are not eligible for state support. Care home residents who receive state support are required to contribute almost all their income in user charges and publicly funded home care users are required to contribute their income above an amount allowed for living costs (subject to some exemptions). This means that people with even moderate levels of assets are at risk of losing their assets down to £23,250 paying for care.

4. Figure 1 shows the estimated distribution of future lifetime care costs that people aged 65 currently face. Around 10% of people aged 65 can expected to experience lifetime case costs exceeding £100,000.

Figure 1: Percentiles of future care costs at age 65 (2010/11 prices)

Based on modelling by personal and social service research unit.

5. People do not know what their lifetime costs will be, so they all face the possibility of very high lifetime costs. A risk-averse person would want to plan for the worst case. The Commission on Funding Care and Support suggested that this leads to asset hoarding, where people are unwilling to release the value from their assets to invest in preventative services, for fear of facing catastrophic costs in later life. Perversely this situation also disincentivises long term savings as those with assets risk losing everything. Those who cannot easily afford to cover what they
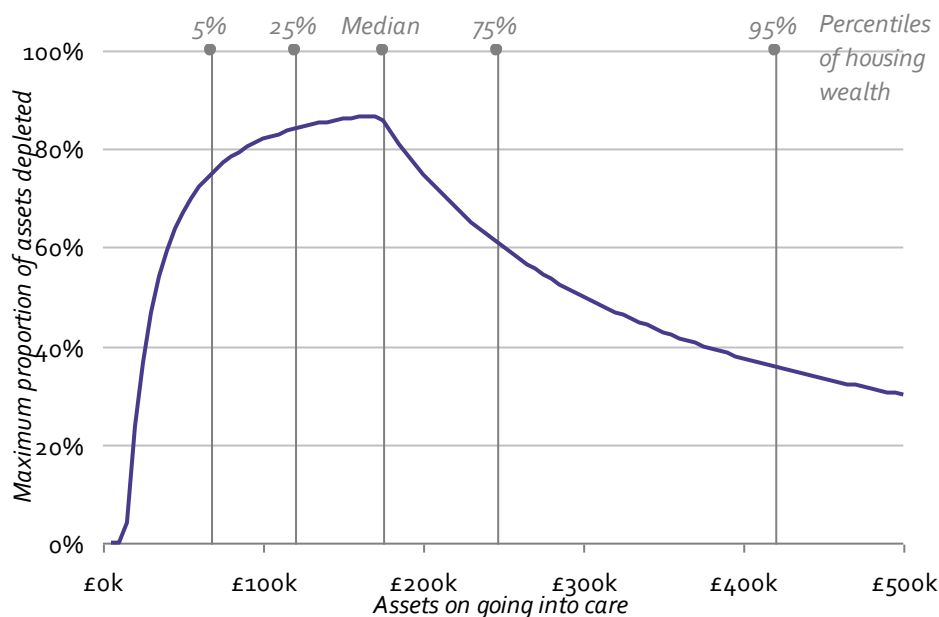
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[1] http://www.dilnotcommission.dh.gov.uk/

[2] https://www.gov.uk/government/publications/government-publishes-progress-report-on-social-care-funding-reform

perceive to be the worst case from their wealth will want, and benefit from, protection from unlimited care costs.

6. Figure 2 illustrates how much someone's assets might deplete if they go into residential care and have eight years worth of residential care costs totalling £150,000 (assuming £10,000 a year living costs in 2010/11 prices). People have around a 1 in 20 chance of having costs of £150,000 or more.

7. Those who are most at risk in this scenario have assets below the median level of housing wealth (for homeowners). They face the possibility of losing almost 90% of their assets paying for their care. These are the people who are least able to manage high costs in the current system, so they are most in need of protection.

Figure 2: Maximum asset depletion under the current system for an individual entering residential care

Based on DH modelling of at the average local authority rate of around £540 per week and facing lifetime care costs of £150,000, by initial level of housing wealth (2010/11 prices)

8. In other areas of our life, when faced with the risk of high costs, people are protected through insurance – either provided by the state (e.g. the NHS) or purchased privately (e.g. house insurance). Pooling risks is welfare enhancing because it provides peace of mind (for risk averse people) and means that people do not have to sacrifice too much consumption to save enough to protect themselves against the worst case scenario.

Background – The Missing Market for Care Insurance

9. Faced with these high and unpredictable costs individuals, people would usually be expected to protect themselves form these risks. However in England, it is not currently possible to buy products which fully pools the risk of long-term care costs. A small market for pre-funded long-term care insurance grew up in the 1990s but products were withdrawn in the 2000s, with insurers citing both supply side and demand side difficulties.

10. The only risk-pooling products currently available are immediate needs annuities (INAs). These products are typically sold to people entering residential care, who make a one-off payment in return for which they usually have their residential care costs covered until they die. They allow people going into residential care to pool their longevity risk, but not the risk of going into residential care in the first place.

11. The lack of an affordable market for care insurance which pools lifetime as well as longevity risk is caused by both demand and supply side factors. Comas-Herra et al.[3] provide an evaluation of the barriers to a fully private insurance system for social care costs.

12. The supply side barriers identified include both adverse selection and uncertainty about future care needs and costs. While the demand side include the high cost and poor affordability of care insurance.

13. People going into residential care are already likely to be in the top quarter of the population by lifetime cost, so this makes the products expensive – a typical INA costs around £85,000[4], although they are priced depending on the individual's risk profile.

14. These products are much easier for the industry to price than pre-funded insurance, as the timescales from premium to payout are much shorter, but they are an incomplete insurance solution for a number of reasons.

   - INAs only allow partial risk-pooling. There is an incomplete market for pooling the remainder of the risk.

   - Partial risk-pooling is inadequate for many people with lower wealth. INAs will only ever be a solution for relatively wealthy people.

15. The absence of an pre-insurance market is a market failure which leads to unfairness and inefficiency. Many people, faced with the prospect of high care costs and being unable to do anything about them, worry about how they will manage when they develop care needs in later life.

16. People who are not able to save sufficient money to cover a worst case scenario will not be able to do anything to prepare for care costs. This will either cause significant worry, or disengagement with the issue.

17. Consumers buying care in a crisis will not make good choices about their care, so will not drive improvements and innovations in the care market.

Background - Commission on Funding of Care and Support

18. The commission on funding care and support (the Dilnot commission) looked at a variety of funding models and concluded that a capped cost model was the best option for funding reform

19. The commission drew upon expert advice and had significant time to investigate options – and recommended that a capped cost system was the best option.

20. The rational for this decision is available in the report and its supporting documents. We do not intend to reproduce this work here.

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[3] Barriers to and opportunities for private Long term care insurance in England: what can we learn from other countries. Adelina Comas-Herrera, Rebecca Butterfield, Jose-Luis Fernandez, Raphaiel Wittenberg and Joshua M. Wiener, Printed in the LSE Companion to Health Policy, Edward Elgar, 2012.

[4] http://www.partnership.co.uk/Documents/Corporate/PR/Immediate%20Needs%20Annuities%20.pdf

Scope of this impact assessment

21. This impact assessment is concerned with the government's proposals for funding reform – the option considered is limited to the proposals within the Care and Support bill.

22. Details such as charging guidance are outside the scope of this impact assessment and will be assessed alongside the relevant regulations.

Policy Objectives

23. The primary objective of the policy is to address the risk individuals face due from unlimited care costs. The reforms should provide people with financial protection from catastrophic care costs and give them with the peace of mind from knowing that they have this protection.

24. There are also secondary objectives:

    - the system encourages people to take responsibility and to plan and prepare for their care needs in later life.

    - any reforms should be financially and politically sustainable, this is important since the benefits depend to a large degree on providing people with predictability about much they may need to contribute towards their care.

    - the system should support the wider objectives for the care and support system including supporting preventative services and the provision of information and advice to enable people to make effective choices about their care and support.

Summary of Options

Option 1: A capped cost model with an extended means test

25. A capped cost model based upon the principles set-out by the Commission on Funding Care and Support as accepted by the government. The parameters of the proposed model are:

   - a cap of around £60,000 in 2010/11 prices (equivalent to £72,000 in 2016/17) on the costs an individual has to pay to meet their eligible care and support needs for adults resident in England;

   - set the cap for those who turn 18 with eligible care and support needs at zero, and set a lower cap for those of working age;

   - for adults in residential care, set the upper capital threshold for means-tested support at £118,000 in 2016/17 (equivalent to around £100,000 in 2010/11). This will be higher than for other types of care, to reflect the fact that the value of the person's home is taken into account when determining how much the person pays towards their care;

   - for adults receiving residential care, increase the lower threshold for the means-test from its 2010/11 value of £14,250 in line with indexation, which subject to assumptions would mean a starting value of around £17,000;

   - Reasonable costs the local authority would be willing to pay to meet all individuals eligible needs will count towards the cap.

26. This option provides financial protection for eligible needs for care and support. Individuals will remain responsible for:

   - a contribution towards general living costs. In residential care, they will pay a contribution of around £10,000 in 2010/11 prices (equivalent to around £12,000 in 2016/17) to help meet expenses associated with room and board;

   - the cost of paying for additional services, beyond which the Local Authority would be willing to pay, such as having a spare room for family visits in a care home; and

   - a contribution towards costs to meet eligible care needs based on tariff income calculation for assets between £17,000 and £118,000 in residential care.

27. The proposal is for the new system to come into effect from April 2016, subject to the passage of legislation.

28. The Commission's report recognised that the care and support system should be sufficiently flexible and responsive to evolve over time. The Government accepts the Commission's recommendation that each of the values should increase over time.

29. In summary, when the reforms take effect from April 2016, we this will mean a :

   - £72,000 cap;

   - £118,000 upper capital limit in residential care;

   - £17,000 lower capital limit in residential care; and

   - around £12,000 contribution to general living costs.

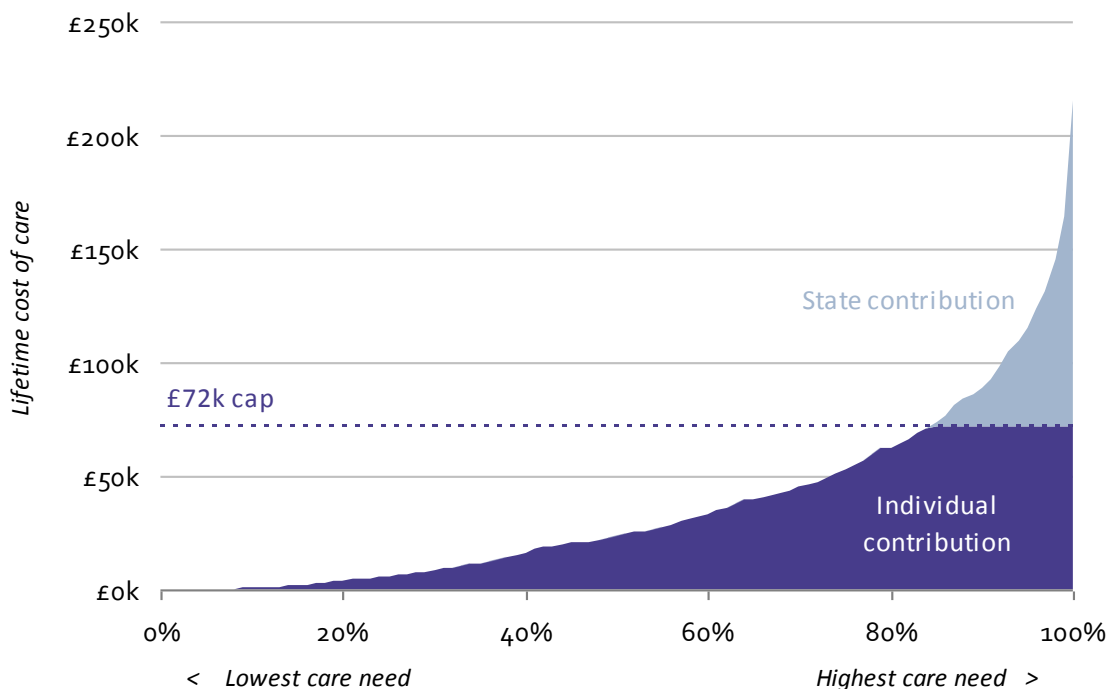30. This impact assessment is based upon assessing the policy as defined by these parameters.

Do Nothing:

31. This would leave the current system as it is. People in residential care would receive state support only when their assets had fallen to around £23,250 (in 2016/17) prices. People would still be unable to protect themselves from the risk of unlimited care costs.
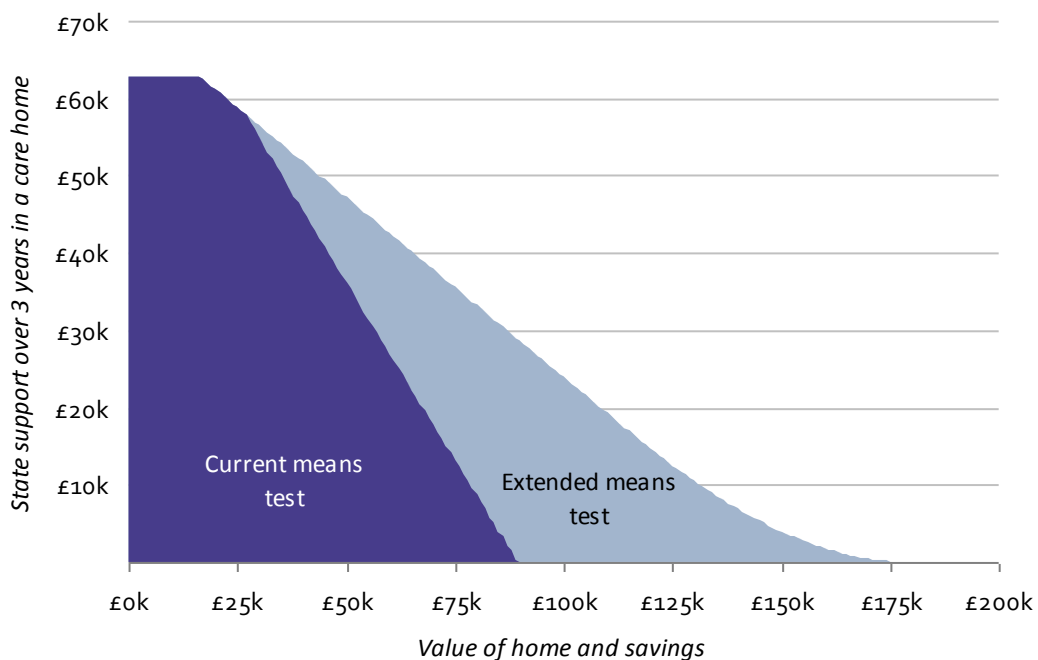
Impact of preferred option (option 1)

32. The cap and extended means-test, define a clear and fair partnership between individuals and the government, with shared responsibility for care costs. People will still have responsibility for their initial care costs, but if they are unlucky enough to need a lot of care, they will not face catastrophic costs.

33. The cap acts to protect people from costs above £72,000 (in 2016/17 prices). As shown by figure 3 below it truncates the distribution of care costs born by individuals and ensures that they are protected from lifetime costs above this amount.

Figure 3: Illustrates how the extreme care costs are eliminated by the cap using a simulated distribution of care costs from PSSRU modelling 2016/17 prices

34. This removes the risk of individuals needing to pay care costs above this amount and makes if feasible for insurance products to be developed to cover the remaining costs. Everyone benefits from the peace of mind from knowing that they will not face unlimited care costs, not just the 16% of older people with care needs who benefit financially from the cap.

35. Meanwhile the extension to the means test for adults in residential care ensures that support. It removes the cliff-edge in the current financial assessment. This will result in a gradual increase in state financial support. Adults with the least wealth will receive financial support towards their care costs and avoid the risk losing all their assets before they reach the cap.
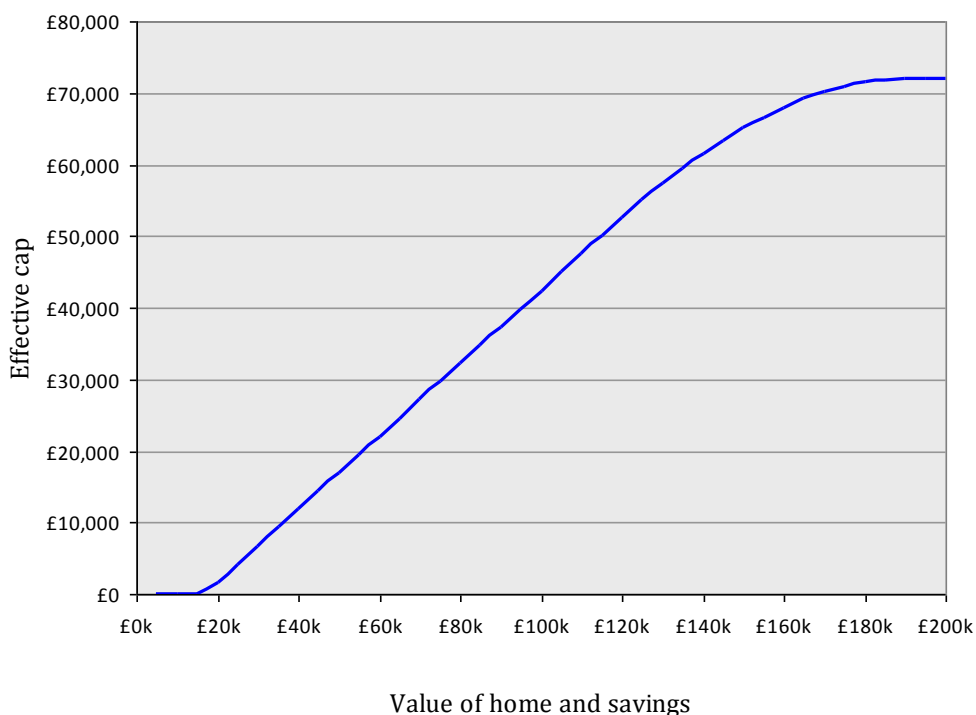
Figure 4: State support from the means test under the current and extended means test for individuals receiving three years of residential care at a projected typical local authority rate in 2016/17 (£625 per week)

Analysis assumes the individual has income equal to the general living costs £223 per week

36. The cost of meeting all people's eligible needs will count towards the cap – rather than their financial contribution. This means that people who fall within the means test will face a lower cap than people outside of it. Figure 5 below shows the amount of the value of their home and savings an individual may have to contribute toward the cost of eligible care needs before reaching the cap – or the effective level of the cap.
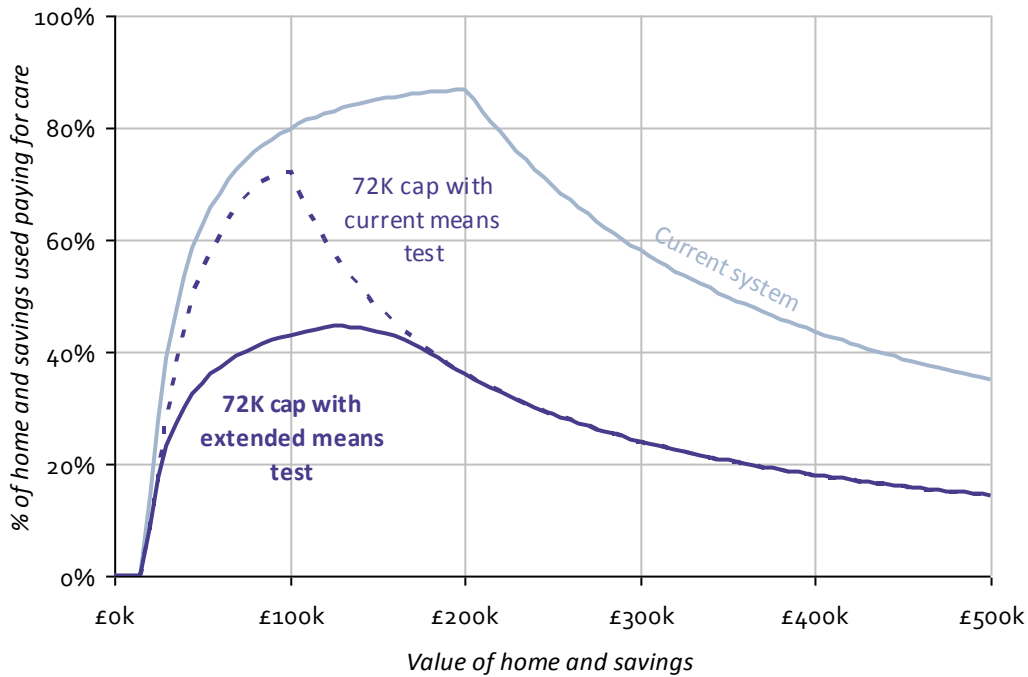
Figure 5 (below): This shows the effective level of the cap for different levels of starting assets (i.e. value of home and savings).
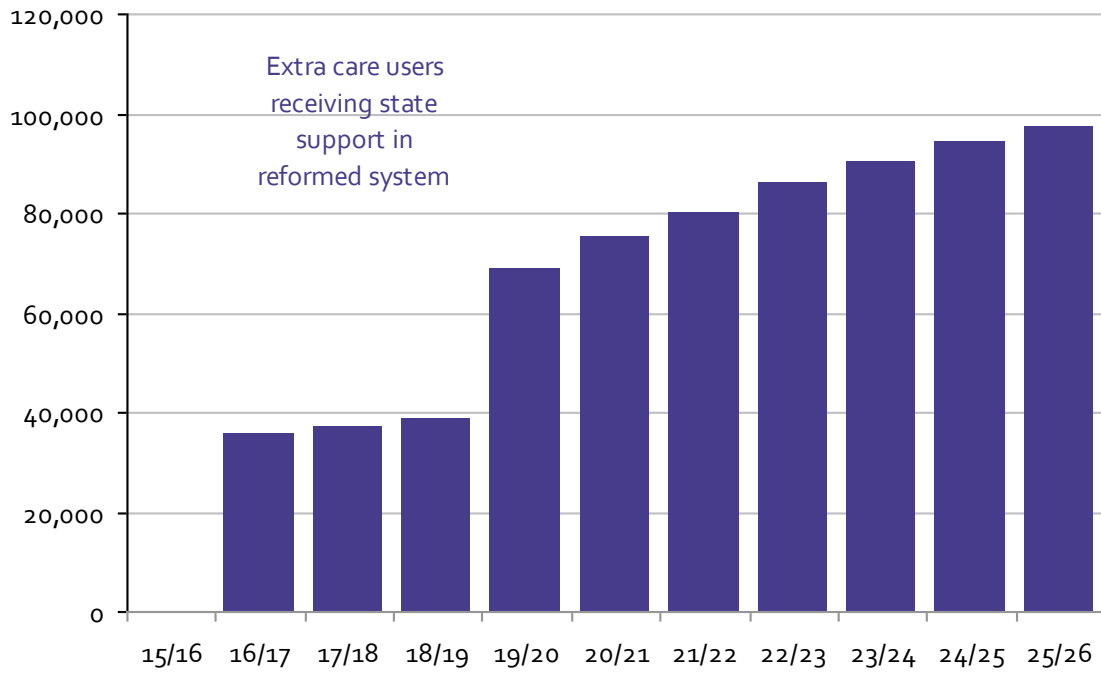
37. Combined the new financial protections through the cap and the extended means test protect people with all levels of assets from unlimited care costs. Figure 6 below shows the asset depletion of a typical individual in a typical local authority with various levels of assets.

38. This is based upon Department of Health modelling of an individual of median income (i.e. with sufficient income to cover their accommodation costs) receiving residential care at a median local authority rate of £540 per week.

Figure 6 : Possible asset depletion for people who enter residential care and have lifetime care costs of £150,000 facing the median Local Authority residential care rate of £540 per week. Source: internal Department of Health analysis

39. Through the combination of the cap and the extended means test this policy protects individuals from unlimited care costs and defines a new partnership between the state and individuals. People will no longer face the risk of losing everything they own to pay for care. The greatest additional protection is provided to those who risk losing the most in the current system. These proposals will extend state support to almost 100,000 more individuals by 2025/26 through the cap and the extended means test as shown by Figure 7 below.

Figure 7: Total number of additional people receiving state support due to the reforms under the proposed option.

Extra care users receiving state support in reformed system

| | 15/16 | 16/17 | 17/18 | 18/19 | 19/20 | 20/21 | 21/22 | 22/23 | 23/24 | 24/25 | 25/26 |

40.   State support is extended to these additional individuals through the combination of the cap and the means test. As the cap provides an universal element to a means tested system, the additional spend goes to those above the lowest quintile (who already receive high levels of state support) and is thus less progressive than current highly means tested system.

41.   However, the reformed social care funding system remains highly progressive with nearly two-thirds of state support focussed on the lowest two quintiles.

Setting the Cap

42. The policy considered here uses a cap of £72,000 in 2016/17 prices equivalent to around £60,000 in 2010/11 prices. Setting the cap affects both the costs and benefits of the policy. In the current fiscal climate it is necessary to strike a balance between competing government spending pressures.

43. The major considerations in setting the cap were:

   - The Commission on Funding Care and Support recommended that an appropriate level of cap in 2010/11 should be £25k to £50k. It also said the cap should inflate over time so that every generation gets a fair deal.

   - Cost of the policy. The amount of resources spent of the cap needed to be balanced against potential other uses for those funds and the government's fiscal objectives.

   - Sustainability of costs over time. The peace of mind benefits of the reforms rely upon people believing the reforms are sustainable over time and that they will be protected from unlimited care costs if they develop care needs. The lower the cap (and conversely the higher the cost of the reforms) the harder it would be to ensure that individuals believe successive governments will remain committed to this policy.

   - The level of protection provided. A lower cap provides greater protection from unlimited care costs.

44. The proposal sets the cap at £72,000 in 2016/17 prices. In order to ensure that proposals were affordable and sustainable it has been necessary to go above the recommended range of the commission with a cap equivalent to around £60,000 in 2010/11 prices.

45. Setting the cap at around £60,000 in 2010/11 prices provide people with protection from unlimited care costs and ensures that the policy is sustainable in the long term. The government has set out how it will ensure that these reforms are fully funded for the next parliament. This funding commitment is vital to achieving the full benefits of these reforms.

Costs of Option 1

Cost of the cap and extended means test for older people

46. This is the amount of money transferred from the state to older people to protect them from unlimited care costs - through the extension to the residential care means test and the introduction of the cap.

Cost of a lower cap for people who develop care needs at working age and free care for those with an eligible care need when they turn 18

47. This is the amount of money transferred from the state to working age adults to protect them from unlimited care costs, through the introduction of a cap and free care for those with an eligible care need at 18.

Cost of additional assessments, care managements and reviews

48. In the new system self-funders will require assessments (and care management and care reviews) to determine their level of need and hence their progress towards the cap.

Reduction in the costs of Attendance Allowance (AA) and Disability Living Allowance (DLA)

49. State funded care home residents have their AA or DLA continued after 28 days of stay, under current practices. The reforms results in more care home residents becoming state funded, through the extended means test and cap on care costs. This results in a reduction in the numbers eligible for AA and DLA and therefore a cost saving.

One off setup costs of implementing the scheme (un-monetised)

50. There may be some setup costs from implementing the scheme, these are likely to be small compared to the overall costs of the policy and their scale is dependant upon the detail of implementation. These could include the cost of changes to systems and processes as well as familiarising staff with the reformed system. We will work with Local Authorities to minimise the value of these costs.

51. All costs both listed above and any others brought our attention through our engagement process with Local Government and the Care and Support Sector will be assessed as part of the new burdens process to ensure that local government is funded to meet them.

Summary of Costs (Option 1)

52. To estimate the costs of option 1, we assume that the current system remains unchanged in place until the implementation date and from April 2016 everyone who meets their Local Authority eligibility criteria commence progress towards the cap.

Figure 8: Summary of costs

£ billions, 10/11 prices	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	NPV
Older People											
Cap and means test	0.36	0.35	0.36	1.15	1.32	1.46	1.62	1.75	1.85	1.94	9.98
Assessment, Case Management and Review Costs	0.21	0.22	0.22	0.23	0.24	0.24	0.25	0.26	0.28	0.29	2.05
Working Age											
all costs	0.10	0.12	0.17	0.21	0.31	0.38	0.39	0.40	0.41	0.42	2.40
Total care and support cost	**0.66**	**0.69**	**0.75**	**1.59**	**1.87**	**2.08**	**2.25**	**2.41**	**2.54**	**2.64**	**14.43**
Savings to benefits	-0.13	-0.13	-0.14	-0.25	-0.27	-0.28	-0.30	-0.31	-0.33	-0.34	-2.06
Net Cost	**0.53**	**0.56**	**0.61**	**1.34**	**1.60**	**1.80**	**1.96**	**2.09**	**2.21**	**2.30**	**12.37**

53. Compared to the "do nothing" option, net public expenditure on care and support is £700 - £800 (2010/11 prices) million greater in the first three years after implementation, with the extra costs arising from the extended means test and free care for those with eligible needs at 18. The net public expenditure on the reformed system increases to £2.7 billion in 2025/26. These are before projected savings due to benefits.

54. Net economic costs and net government costs are equal as all costs for this policy will be borne by the government.

Analysis of costs

55. The analysis in this impact assessment considers projections of likely costs; this means that they are based on a series of assumptions about future trends in relevant factors, such as demography, prevalence of disability and unit costs of care services.

56. The costs have been estimated by simulating a sample of care journeys assessed at typical local authority rates for the care they receive. This is based upon data from the English Longitudinal Study of Aging[5] adjusted for changing demographics and costs over time.

Older Adults

57. The older adults costs presented in this analysis are from the Department of Health (DH) Social Care Funding Model. This estimates the percentage increase in costs of the reform options over projections of the spend on the current funding system taken from modelling provided by the Personal Social Services Research Unit (PSSRU) – a collaboration of three universities all ranked outstanding by international criteria which brings together leading experts in the field .

58. The DH model takes a sample of care journeys derived from the English Longitudinal Study of Ageing and simulates the cost to the model of meeting these.

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[5] http://www.ifs.org.uk/ELSA

Working Age Adults

59. People who develop care needs before they turn 18 will receive free social care and there will be a lower cap for those of working age. DH will be consulting upon the details of the cap for working age adults over the summer. The costs are based on the recommendation of the Dilnot commission of free care for those with eligible care needs at 18 and a tiered cap up to the £72,000 cap for older adults.

Figure 9: Modelled tiered cap for people of working age

Age group	Cap level in 2016/17
<40	Free care
40-44	25,000
45-54	40,000
55-64	60,000

NB: The cap levels here are used to model the cost of the reforms but do not represent government policy. DH will be consulting upon the implementation of the reforms including the appropriate level of the cap for different age groups over the summer.

60. There is less data and information on younger adults with care and support needs. The analysis for working age adults takes estimates from PSSRU for the projected costs of the current system and of a "zero cap" option to produce an estimate of the cost of the reform option between the two bounds based upon the modelled cap above.

61. We therefore present the costs of the reform for older adults and working age adults separately to reflect the difference in the reform option for these two groups and the difference in the methodologies in estimating the costs.

Assessments, care management and benefits

62. The extra costs for additional assessments and care management and the savings due to the reduction in Attendance Allowance and Disability Living Allowance (and the future replacement for DLA's with the Personal Independence Payment) are estimated in further analysis by DH analysts using inputs from both DH modelling and PSSRU modelling. Further details on the analysis can be found in Annex B.

Costs of Option 2: Do nothing

63. The do nothing option would not incur the additional costs of the proposed option. Costs would simply rise in line with rising care costs and demographic pressures and people would still face unlimited care costs.

64. With the aging population more people would be forced to deplete all their assets to pay for care, placing increased strain on families, friends and local communities.

Benefits (of capped cost model)

65. The Monetised benefits of the reforms include:

- **Peace of mind to everyone from knowing that they will not face unlimited care costs**. Everyone will benefit from the peace of mind from knowing that they do not risk facing unlimited care costs. This is an insurance benefit it accrues even to individuals who do not encounter catastrophic care costs.

- **Financial benefits to both older people and of working age adults who receive state support.** Individuals who currently do not receive state support will be financially better off as a result of the reforms. This represents a transfer from the state to the individuals receiving state support.

- **Savings to benefits.** People who receive state support towards their care through the extended means test will lose eligibility for some Disability Living Allowance and Attendance Allowance support. However this will be offset by the extra means tested support. No individual will be worse off as a result of these reforms.

66. The non-monetised benefits of the reforms include:

- **Encouraging people to take responsibility and to plan and prepare for their care needs in later life**.

- **Creating a space for financial services products** which enable people to further mitigate their risks and gain additional peace of mind benefits.

- **Wider benefits from supporting other objectives for the care and support system** including supporting preventative services and the provision of information and advice.

Double counting

67. To avoid double counting the benefits of this policy we cannot include both the insurance benefit individuals' gain from being covered by the cap and the financial transfers to individuals facing very high care costs.

68. Therefore the monetised benefits have been split into the direct financial transfers and the additional peace of mind from the insurance. This ensures that the benefits are not double counted.

Figure 10: Monetised benefits of the reforms.

£ billions, 10/11 prices	*16/17*	*17/18*	*18/19*	*19/20*	*20/21*	*21/22*	*22/23*	*23/24*	*24/25*	*25/26*	*NPV*
Financial transfers to older people	0.36	0.35	0.36	1.15	1.32	1.46	1.62	1.75	1.85	1.94	9.98
Financial transfers to working age adults	0.10	0.12	0.17	0.21	0.31	0.38	0.39	0.40	0.41	0.42	2.40
Savings to benefits	-0.13	-0.13	-0.14	-0.25	-0.27	-0.28	-0.30	-0.31	-0.33	-0.34	-2.06
Additional peace of mind	0.14	0.15	0.17	0.48	0.58	0.67	0.74	0.79	0.83	0.87	4.44
Net Benefits	0.47	0.49	0.56	1.59	1.94	2.23	2.45	2.63	2.76	2.89	14.76

Monetised benefits

69. This impact assessment splits the financial benefits of the reforms into the direct financial transfers and the additional "peace of mind" benefits generated through this social insurance system.

Peace of Mind Benefits

70. Funding reform is a type of social insurance and people generally value insurance more highly than the value of the expected payout. Purchasers of insurance pay more for insurance than they expect to get out of it: this is because insurance premiums need to cover admin costs, profits and the accumulation of reserves, as well as benefit payments.

71. People are often willing to pay more than the expected benefits for financial protection, because most people are risk averse and worry about the uncertainty surrounding future losses e.g. in this case care costs. Insurance gives them peace of mind.

72. A capped cost system will lead to a net welfare gain for the population since risk-averse people would be wiling to pay premiums exceeding the costs.

73. We calculate this welfare gain by using information on loss ratios from long-term care insurance markets in the USA, where the loss ratio is 60% for individual policies. The loss ratio is the proportion of premium income that the insurer pays out on claims.

74. We estimate that for each pound of long-term care risk transferred to the state, an individual picked at random from the over 65-year-old population would be willing to pay around £1.43. Further details on the approach to valuing peace of mind benefits are at Annex A.

75. There are several assumptions in this work most notably it assumes constant risk aversion, that the USA data is applicable to the UK. Since we do not have data for working age adults we have assumed that this figure is applicable to individuals of all ages.

76. This means that there are peace of mind benefits of 43% above the value of the state support provided to individuals needing care and support.

77. There are several potential sensitivities that could affect the value of peace of mind benefits these could either reduce or increace the peace of mind benefits.

Reducing peace of mind benefits

- Higher average wealth in the USA may create a greater demand for insurance.
- Lower levels of social insurance (in other areas) in the US may create a greater demand for insurance.

Increasing peace of mind benefits

- The methodology assumes that no individuals are willing to pay more than the market price if as consumer surplus indicates some individuals are willing to pay more than the market price then the average peace of mind benefit would be higher.
- Peace of mind benefits will occur before spending on the policy. For example people may already have some peace of mind from knowing that a cap on care costs will be introduced in 2016. This would tend to increase the effect as people value benefits now more than future ones.

78. Since this is a relatively uncertain value we have tested the various values for peace of mind benefits. As long as the benefits are greater than 20% then the policy has a positive net present value. This means that even if the value of the peace of mind benefits is half what we have estimated the policy is still justified in terms of its monetised costs and benefits.

79. For the purposes of this impact assessment we have assumed that all peace of mind benefits occur when funds are spent. This is the most conservative assumption we could make– any proposals which spread these benefits over a longer time period (and therefore with the benefits occurring before the costs) will increase the merit of these proposals.

80. One potential option is for all the benefits of the policy to occur at once – in this view the state has effectively given everyone a free care insurance policy.

81. In this view the entire net present value of the policy would occur in 16/17 (or arguably before this, from when the policy was announced). Assuming an individual's value of the insurance policy at any point in time is based upon its net present value as is societies at large then these two different views would not affect the overall NPV of the policy.

Non-monetised Benefits

Encourages people to take responsibility and to plan and prepare for their care needs in later life

82. Through providing protection from unlimited care costs the proposals provide people with incentives to plan for their future care needs. People will be informed that they will be protected from unlimited care costs and this will encourage them to plan for and manage the cost they do place.

83. By putting in place plans for future care needs this will reduce the need to make pressured decisions in a crisis, which are often not in service users best interests.

Support for wider government objectives around planning, preparation and prevention

84. The overarching government policy objective is to secure better outcomes and experience of care for service users, their carers and families. The reforms are designed to support this overarching objective – two areas where the proposals for funding reform could make a particularly significant contribution are around prevention and intervention.

85. In the current system, many people funding their own care will have very little contact, if at all, with their local authority. The introduction of a cap on care costs will encourage people to make contact. The care assessments will provide an opportunity for self-funders to access information and advice from their local authority and to make choices about the care services available in their local area.

86. While the proposals create no direct benefits in this area they may enable other government polices to enable people to access information and advice around their care operate more effectively making effective use this additional contact individuals have with local authorities.

Space for financial services products

87. Some people may choose to plan for the future by using financial products. The current options for people to protect themselves are limited to immediate needs annuities. The financial services industry support the reforms, since the limit on people's care costs will provide greater incentives to provide relevant products that people see the benefit of purchasing.

88. The Government expects the financial services industry to work creatively to amend existing products and develop new products that support people in making choices about how to plan for their care costs.

Risks and Assumptions

89. The costs and benefits within this impact assessment represent the most likely affects of the policy. However in any social care system there are several key assumptions on drivers of demand which will affect the overall projected future level of spending on social care.

Demand for formal care and support follows projections produced by the Personal and Social Service Research Unit

90. The modelling assumes the demand for formal care and support grows according to the PSSRU aggregate modelling which projects social care demand from demographic trends. This assumes that the both the trends are accurate and that they are not significantly affected by the implementation of the reforms.

Proportion of care users who meet LA eligibility criteria

91. The modelling is based upon estimates of current social care eligibility among self funders. This assumes that the proportion of care users who have local authority assessed eligible needs remains the same as at present. Changes to local authority assessed eligibility, potentially as a result of the setting of a national minimum eligibility threshold, could affect the cost and benefit calculations.

Care costs rise by two percent per year in real terms

92. The modelling assumes that care costs rise at GDP deflator plus two percent per year, equivalent to a real terms increase of 2% per year based upon projected care cost inflation as used by the Commission on Funding Care and Support. This makes no requirement for efficiency gains in the provision of social care services.

93. At the last spending review efficiency was estimated at 3% per year. While this may not be sustainable in the long term if efficiencies were 2% per year this would result in around £190 million of savings per year in 2024/25.

Effects on local authority processes and systems

94. The reforms will bring many more people into contact the local authorities and this may create challenges as well as opportunities. The Department of Health is engaging with local authorities to better understand any impacts on local authority's processes.

95. One possible impact is on the number of disputes around both care and financial assessments, which could rise in line with the number of assessments. However this may be counteracted by the fact we are moving from a system where people might have everything to lose, which puts an immense pressure on the boundary between health and social care, resulting in legal disputes over continuing healthcare, to one where people have clarity on the risks they face if they have care and support needs. This should help reduce, rather than increase the overall number of legal disputes.

96. The Department of Health is working with local authorities through its engagement process and forthcoming consultation on the detail of implementation to better understand this and any other impacts.

Impact of the reforms on the demand for care and support

97. The costs and benefits of these reforms are based upon the estimates of projected social care users produced by the PSSRU aggregate model. This models both publicly and privately funded future social care users.

98. The PSSRU projections are produced by a group of academic experts and subject a peer review process.

99. However there is the possibility that the significant changes to the social care funding system proposed could influence the underlying demand for care and support. The department has identified two possible influences:

   - The impact on informal care provision.

   - The impact on unmet need.

Informal Care Provision

100. Informal carers do vital work supporting people with care needs. In 2011 there were around 5.8 million people in England and Wales providing unpaid care (informal care).[6]

101. There is a theoretical argument that informal care may be reduced through these reforms. This is because at present people may undertake caring to protect people (such as their parents) from facing unlimited care costs. Since the state will be providing that protection – and in some circumstances directly funding peoples care there is potentially a lower incentive to undertake caring activities.

102. We do not consider this effect likely from two main reasons:

   a. Evidence suggests that financial gain is not the major motivation for informal care provision and hence that we are unlikely to see a reduction in informal care provision. Additionally the provisions of the bill, to support carers and help them undertake caring activities will mitigate any effect.

   b. The financial benefit individuals could potentially gain from reduced informal care provision is remote. Decisions on informal care are likely to occur early in care pathways when the prospect of receiving state support from the cap is unlikely to be a major influence on people's decisions about care.[7]

103. We have also looked at evidence from Scotland where they have introduced greater state support for people with care needs than England. Bell, Bowes and Heitmueller's (2006) analysis of these reforms found that the number of carers and the amount of care provided did not reduce compared to the rest of the UK. However, there was a change in the composition of care. The number of hours of intensive personal care fell, but the amount of low-intensity care increased.

104. They argued that there analysis rules out any "immediate catastrophic fall in informal care arising from the introduction of free personal care" while they cannot make longer term projections they found that the money set aside by the Scottish government to fund a reduction in informal care may have been unnecessary.

105. These results are supported by recent work from the Office of Health Economics in 2013 which compared Scotland an England before and after the reforms as a natural experiment [8] using a similar methodology. This found that there was a 3-5% rise in informal care in Scotland after the introduction of free informal care.

106. We therefore think it unlikely that there will be significant negative changes in informal care provision due to these reforms. Even if an effect were to occur the increase costs to state would be mitigated by the benefits of freeing informal carers to return to work.

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[6] Census 2011 Data.

[7] The extended means test only applies in residential care where there is little scope for informal care provision

[8] Schaffer, Sarah Karlsberg. (2013) *The effect of free personal care for the elderly on informal caregiving.* Research paper 13/01. London: Office of Health Economics.

107. Informal care is, and will remain a vital comment of the care and support system. The Care and Support Bill will provide greater support to carers than ever before. We will work with local government and the care and support sector to understand and mitigate any negative impacts.

Unmet need

108. The reforms may help facilitate access to hard to reach individuals who are currently in need of care and support but not receiving it then this would be a significant benefit of the policy. It would lead to welfare improvements these individuals, which would likely be in excess of the costs of the extra support they received.

109. We do not expect any significant impacts in this area but through our engagement we will be exploring how the opportunities of funding reform can be used to support the Government's wider objectives in ensuring everyone has access to care service.

110. Any impact of these reforms on unmet need to be small. We are unable to estimate the size of this effect due to a lack of sufficient data.

Sensitivity analysis

111. The costs of a cap are based on a number of assumptions; e.g. people's care journeys, duration of care, take-up of the capped offer, and the distribution of incomes and wealth.

112. More generally in any social care system there are several key assumptions on drivers of demand which will affect the overall projected future level of spending on social care. These are the unit costs of care, life expectancy and prevalence of disability.

113. If social care unit costs were to rise 1 percentage point faster than the base case assumptions, costs of in 2025/26 would be 12% higher in real terms than the base case costs. If there were efficiency savings 1% below this projection, then the costs would be 9% lower.

114. If life expectancy is less than assumed in the Office for National Statistics (ONS) central projections there will be fewer people and the costs of care will be lower. Compared to the base case, costs of the current and capped cost system will be 2.5% lower/higher in 2025/26 under the ONS lower/higher life expectancy scenario.

115. In work for the Commission on Funding Care and Support, the PSSRU examined the sensitivity of the current system costs to changes in the prevalence of disability. Under their more optimistic scenario, in which prevalence rates of disability fall by 1% per year, real terms costs in 2025/26 of the current system are 15% lower than the base case (in which rates remain constant). Under a more pessimistic scenario where the rates rise by 1% per year, costs of the current system increase by 15%.

116. We have not explicitly modelled the sensitivity of a capped cost system to prevalence; however it should be broadly similar to the current system discussed above.

117. However, one of the most important strengths of our proposals – and a key advantage of this approach over other funding models – is that it is flexible enough to adapt to demographic and other pressures. The Care and Support Bill sets out how the cap will change over time and review the system to provide people with certainty about their potential future costs. Government will also retain the ability in secondary legislation to change the level of the cap, in response to demographic trends or other funding pressures, without undermining the benefits of the system. The sensitivity analysis therefore needs to be seen in this context, and uncertainty around future trends in the drivers of need is not a significant risk to sustainability.

118. For further detail see annex B which includes full sensitivity tests.

Specific Impact Tests

Equalities

119. The Department of Health conducted an extensive engagement with care users and members of the care sector on reform of social care, including funding reform. The engagement found support for a capped costs model. There has been extensive engagement with older people's disabilities groups to ensure that their views are fully reflected in the policy.

120. The scheme will not discriminate on the basis of equalities characteristics such as old age, gender, sexual orientation, belief or socio-economic status.

121. The direct financial beneficiaries of these reforms should reflect the makeup of people in receiving care and support – as such we expect they will cater main to disabled and older people, predominantly women.

122. The impact upon specific groups depends upon the details of implementation. We will be consulting on the details over the summer which will provide an opportunity to inform and shape the work to ensure that the reforms treat all individual fairly and reflect the different circumstances people face. We will look to improve the evidence base both through this consultation and direct engagement with representative groups within the care and support sector.

123. Through engagement and consultation we will work to ensure that all individuals are able to access and benefit from these reforms regardless of their characteristics.

124. The impact of these reforms on specific characteristics is listed below.

Disability

125. Those with eligible care needs will likely have some form of disability. People will get the same protection, regardless of the type of disability they have.

126. The financial benefits of the reforms will be focused upon disabled people who will benefit from protection from unlimited care costs. They will also likely to benefit from greater peace of mind.

Age + Sex

127. Those who currently face the highest depletion of assets due to care will benefit the most financially from the cap on costs. These individuals are likely to be predominantly old (92% over 75) and female (78% are female).[9]

128. The government has committed to free care for those who develop care needs before they turn 18 and a lower cap for people who develop care needs when of working age. This ensures that the cap people face is proportionate both to their ability to plan for care needs and the level of assets they can accumulate. In developing detailed proposals for the level of the cap for working age adults of different ages we will work to ensure that our proposals equitable for all groups and meet the Public Sector Equalities Duties.

Race

129. The reforms will not discriminate on the basis of race. However, it is possible that due to differences in the need for formal care there may be different distributions of benefits among different ethnic groups.

130. The Joseph Rowtree Foundation note that minority ethnic groups are more likely to be living in larger houses with one or more carer. [10] This may mean they have a lower need for formal care and support they are in less need of protection from unlimited care costs and may receive less benefits from the reforms.

Religion or Belief

131. The particular religions require specifically designed financial products to abide with religious beliefs. The capped part of the reform, along with greater consistency in assessment allows for the development of financial products. In order for those with religious requirements to benefit, carefully designed financial products would have to be provided in the private sector. We are engaging

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[9] Care of Elderly UK Market Survey, 2011-12, Laing and Buisson (2012)

[10] *Changes in communal provision for adult social care: 1991-2001,* Joseph Rowntree Foundation (2006)

extensively with the sector to help ensure that suitable products are available for all sections of society.

Gender Reassignment, Sexual Orientation and Marriage and Civil Partnership-

132. None of the changes to the system will impact differentially on these groups. However since these individuals may be less likely to have children (who often form part of extended support networks for older people) they may have a higher risk of unlimited care costs (since they rely on more formal care) and hence a greater benefit from these reforms.

Pregnancy and maternity

133. No differential impact identified - pregnant women are likely to be of working age and therefore will benefit from a lower cap. While mothers may have lower lifetime assets and thus might receive a lower benefit from these changes (as they are already protected by the existing system).

Socio-economic status

134. All socio-economic groups should benefit from these reforms. The reforms provide universal protection from unlimited care costs ensuring everyone can benefit from peace of mind due to knowing that they are protected from unlimited care costs whatever their future wealth and income.
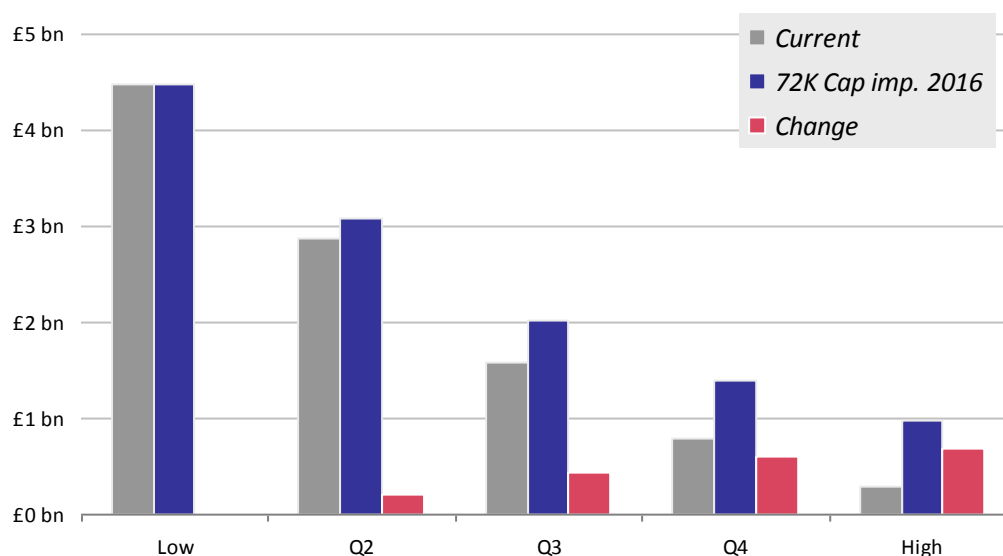
135. Since people do not know in advance what their income and assets will be when they require care and support. To provide the maximum financial security to individuals who do not know their income and assets in old age the reforms offer universal protection from unlimited care costs.

136. Adding universal element of the cap to the existing means tested system will lead to the direct financial benefits of the reforms being focused upon higher income and asset quintiles.

137. Those with low incomes and wealth when they develop care needs will be financially unaffected by the current proposals, since their wealth is already protected by the current means test. However they will still benefit from increase peace of mind as they know whatever their wealth they will be protected from unlimited care costs.

138. Individuals in higher income and asset quintiles who receive little or no support under the current system will gain direct financial benefits from the cap. As demonstrated by the chart below.

Figure 11: Social care funding by combined income and asset quintiles of older people receiving Adult Social Care under the current and the proposed system in 2024/25.

*11

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[11] Current system projected costs based on modelling by PSSRU future spending will depend upon the decisions taken at the appropriate spending round.

Figure 12: The combined income and asset quintiles used in the chart above (DH analysis) 2010/11 prices

	Income						
Assets	£5k	£8k	£10k	£13k	£15k	£18k	£20k
No assets	1	1	2	2	2	2	2
£50k	2	2	2	3	3	3	3
£70k	2	3	3	3	3	3	3
£100k	3	3	3	3	3	3	3
£150k	3	3	4	4	4	4	4
£200k	4	4	4	4	4	5	5
£300k	5	5	5	5	5	5	5

Marriage and Civil Partnership*

139. Couples, either Married or in a Civil Partnership will benefit equally from the protection of the cap and extended means test. Charging guidance which ensures that peoples housing assets are disregarded for the purposes of the means test while another partner remains living in it.

Specific Impact Tests

One in, two out:

140. The impacts presented in this impact assessment do not fall under the one in, two out rule as the capped cost model does not involve new burdens on business or civil society.

Sunset clause

141. As above, the obligation to include a sunset clause does not apply as social care funding reform does not involve new regulation on business or civil society.

Micro enterprise exemption from regulation

142. Funding reform does not involve new regulation on business or civil society.

Small Firms Impact Test

143. Funding reform has no impact on small firms we discuss regulatory impacts below relating to financial providers, which are exclusively larger businesses.

Competition

144. Funding reform itself has no impact upon the operation of competition. With regards to the market for financial services the changes in limiting care costs to £72,000 and our work with the sector will stimulate entry into the market and greater competition. While the small existing market for INA's may be negatively affected this will be more than the compensated for by the opportunities for these providers in the new liberated market for financial products to provide people with additional protection up to the cap.

145. There are no identifiable impacts upon the competition in the care sector since these reforms will affect only how care is funded and the balance of costs between individuals and the state. We will work to identify any impacts through are engagement and to ensure that any impacts on the sector our positive when designing the detail of implementation.

Environmental and sustainability impacts:

146. These reforms have no impact upon the environment or sustainability.

Human rights

147. There will no negative impact on human rights.

Justice system impacts

148. There are no implications from funding reform for the justice system.

Rural proofing

149. Funding reform will benefit everyone no matter where they are in the country. We will be considering any differential impacts upon rural areas, during our engagement on the detail of implementing these reforms.

150. The Department of Health have recently commissioned a review of the adult social care relative needs formulae. This review of the funding formulae will take account of the reforms to the social care funding system and will consider rural impacts. The review is being carried out by independent experts at LG Futures and the Personal Social Services Research Unit at the University of Kent. Further information can be found at http://www.lgfutures.co.uk/adultsocialcarernf

ANNEX A – Peace of Mind Methodologies

Loss Ratio Approach

A1 We used findings from the long-term care insurance (LTCI) market in the USA to estimate willingness to pay for insurance against care costs, over and above the actuarially fair premium. In particular, we looked at LTCI loss ratios.

A2 The loss ratio is the amount that an insurer pays out on claims divided by the amount it collects in premiums. From the provider's perspective, the loss ratio is less than one to allow for administration costs, profits and the accumulation of reserves. The size of the loss ratio is a supply-side decision.

A3 On the demand-side, however, individuals face a binary choice given the size of the loss ratio: buy insurance or do not buy insurance. If the individual buys insurance given a loss ratio less than one, then on average they will be worse off in monetary terms. In turn, this means that the individual must perceive that they will be better off in other ways. We suggest that people are willing to accept the monetary cost because they value the peace of mind that insurance provides; essentially, they are buying the peace of mind. Therefore, by isolating how much 'worse off' in monetary terms the individual is on average, we estimate how much 'better off' they are in terms of their peace of mind.

A4 Using information from the USA, we estimate that between 40% and 60% of the total premiums collected by LTC insurers is not paid out on claims. Our hypothesis is that, on average, those who buy LTCI pay 40% of their premium for the peace of mind that coverage brings. In the following, we define the Peace of Mind (POM) Ratio as 1-loss ratio.

A5 Work from PSSRU on immediate needs annuities in the UK suggests a similar premium where INA's cost around £100,000 but have an actuarial value of only around £70,000. This means that around 40% of the premium is paid for the peace of mind supporting the results from the US.

The Buyers of LTCI

A6 Most older people in the US do not have LTCI. A study by American Health Insurance Plans (AHIP) (2007), a trade body for health insurers in the US, finds that only 16% of over 65 year olds are covered by LTCI. For our purposes, this means that 16% of older people think the benefit of LTCI is greater than or equal to the cost. Therefore, we expect most buyers to have been willing to pay more for the insurance than they had to.

The Non-Buyers

A7 The AHIP study also surveyed non-buyers (representing the remaining 84% of the older population), to ascertain how much they would have been willing to pay for insurance. The study finds that 15% of non-buyers were willing to pay (at least) the market premium, but could not afford to do so. A further 15% of non-buyers would not be willing to pay for LTCI under any circumstances. Using the study, we also estimate that the remaining 70% of non-buyers would have bought insurance had it cost 73% of the market premium.

A8 Clearly, different people are willing to pay different amounts for long-term care insurance. Some non-buyers would be willing to buy LTCI if the premium was lower, or, equivalently, if the loss ratio was higher. Using the information in the AHIP (2007) study, we estimate the average acceptable loss ratio to be around 0.7. This means that on average, an older person picked at random would be willing to purchase LTCI, if for every pound of premium she paid, she received 70 pence of coverage. In turn, this means that on average the individual would be willing to pay 30 pence (or 43% of the actuarially fair price) for the peace of mind that insurance brings (i.e. the POM ratio is 30%).

Caveats

Transferring Lessons from the USA

A9 In our analysis, we rely on people in the UK having similar risk preferences to people in the USA. We do not have evidence on the validity of this assumption. However, these results appear correlate with the limited evidence from the Immediate Needs Annuity Market in the UK.

Constant Risk Aversion

A10 In our methodology, we implicitly assume that each pound of risk that the state covers is of a constant value to the individual. In practice, we do not expect this assumption to be realistic. Holt and Laury (2002), for example, find that increasing the scale of payoffs increases the level of risk aversion. Therefore, we expect insurance that removes low probability, but high loss risks to be of greater value to the individual than insurance that covers against lower cost but greater probability risks.

A11 We do not adjust for varying risk aversion, because we do not know the extent and pattern of the variation.

Sustainability of the Scheme

A12 Insurance only delivers peace of mind if the insured believe that the insurer will pay out. In terms of the universal protection from the cap on care costs, this means that the welfare gain will only apply if people believe that the funding system will be in place for their lifetime. In turn, this means that there is some trade-off between comprehensiveness and sustainability. A fully comprehensive insurance product, such as the NHS, will only provide peace of mind if it is believed to be sustainable.

A13 The government has thus committed to a fully funded scheme which is sustainable in the long term. We have therefore set the cap at a level which is affordable.
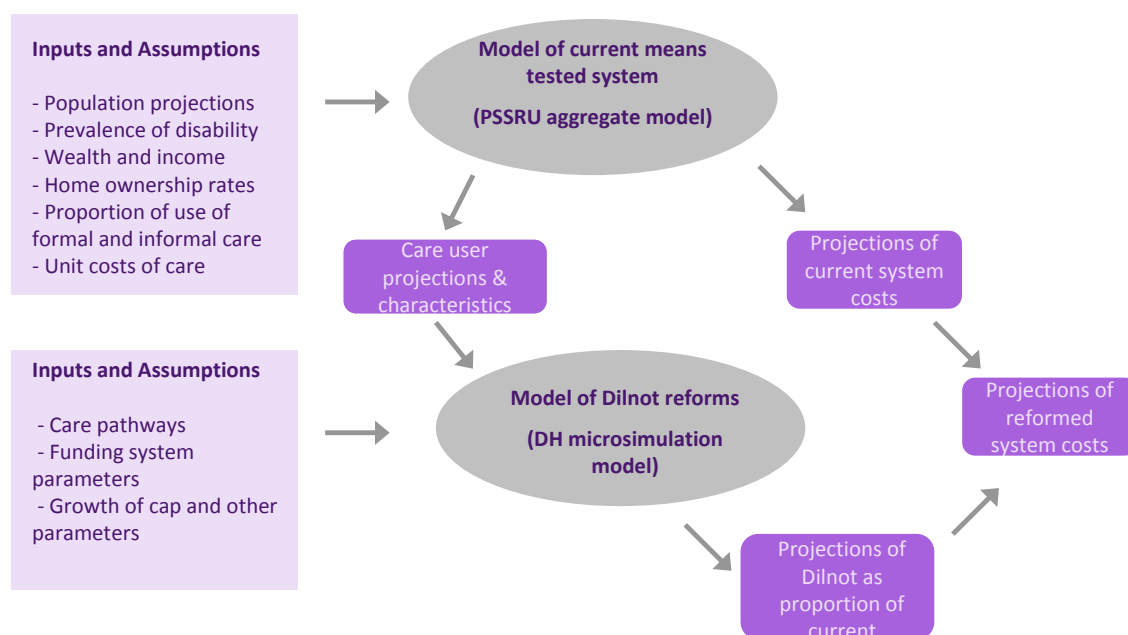
Annex B: Modelling of Social Care Funding Reforms

B1 The costs presented in this Impact Assessment are projections of the likely costs of the reforms. They are based on a series of assumptions about future trends in relevant factors, including demography, the prevalence of disability and unit costs of care services.

B2 The costs have been estimated on the basis of national average data, to produce estimated costs at a national level. We will be working with local authorities to better understand the impact of variation in social, economic and demographic conditions in individual local authority areas.

B3 The Department of Health have recently commissioned a review of the adult social care relative needs formulae used to distribute social care funding to local authorities. This review will take account of the reforms to the social care funding system. The review is being carried out by independent experts at LG Futures and the Personal Social Services Research Unit at the University of Kent. Further information can be found at http://www.lgfutures.co.uk/adultsocialcarernf

B4 This annex provides further information on the modelling and analysis used to estimate the costs of the reforms.

Older Adults

B5 The increased public expenditure due to the increased state support for older adults due to the cap and extended residential care means test are modelled using the Department of Health (DH) social care funding model. *The model does not make forecasts about the future.* It makes projections on the basis of forecast about future trends.

B6 The DH social care funding model is an excel based micro-simulation model which runs using VBA code. DH analysts designed and developed the model to analyse different funding reform options, including changes to the social care means test and the implementation of a capped cost system. The key outputs of the model are total public spend on older adult social care and the distribution of spend by income and wealth of the different reforms. The model also allows the impact of different reforms to be analysed at an individual level.

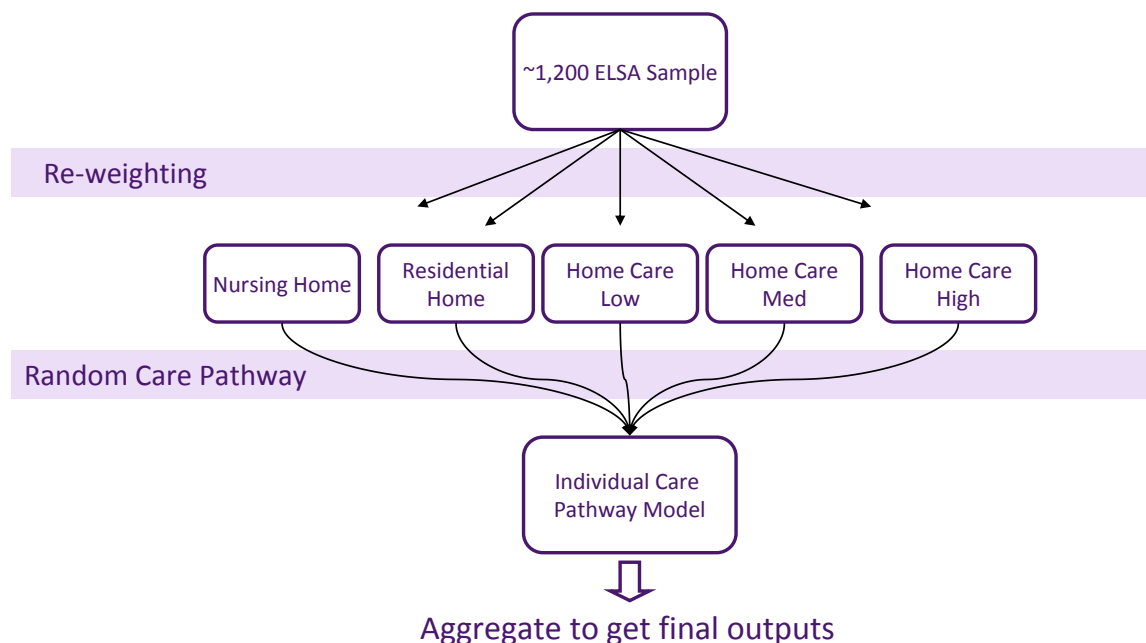**Figure 13: Older adults modelling architecture**

B7 The DH model fits into a modelling architecture where the DH model takes inputs from the Personal Social Services Research Unit (PSSRU) aggregate model on the future projections of the number of care users and their characteristics and the projected costs of the current system. This forms the baseline onto which the percentage increase in costs for the reformed system estimated by the DH model is applied to produce the final cost estimate.

B8 The DH model is a cross-sectional model that retro speculatively simulates uncompleted care journeys of a representative cross section of care users in the cross-sectional month being modelled. It independently models October in the years 2010/11 to 2025/26. These yearly mid point estimates are multiplied up to produce whole year estimates.

B9 The base sample used in the model is the ADL (activity of daily living) disabled 65+ population from wave 4 of the English Longitudinal Study of Ageing (ELSA)[1]. It models 5 care settings separately; nursing homes, residential homes and 3 levels of home care (low, medium and high intensity).

B10 For each care setting the model runs a representative sample through an individual care pathway model. The representative sample is generated by weighting the sample for each year and care setting using weights derived from outputs from the PSSRU aggregate model of the number and characteristics of care users.

Figure 14: VBA structure of DH social care funding model

B11 Each individual in the sample is randomly assigned an uncompleted care pathway from a derived distribution of all uncompleted care pathways. The survey data used to derive the distribution is length of stay in (BUPA) care homes (PSSRU) [2], Admissions to care homes and home care survey 2005 (PSSRU) [3] and 2006 User Experience Survey[4]. Monte-carlo methods are used to average out the variation in outputs resulting in the random selection of care pathways.

B12 The individual care pathway model computes the state and private spend for each month of the care pathway, this is dependent on the individuals characteristics (income, wealth, household type, housing tenure) and the funding system being modelled. The quantities of the cross-sectional month are aggregated using the weights to produce population level estimates.
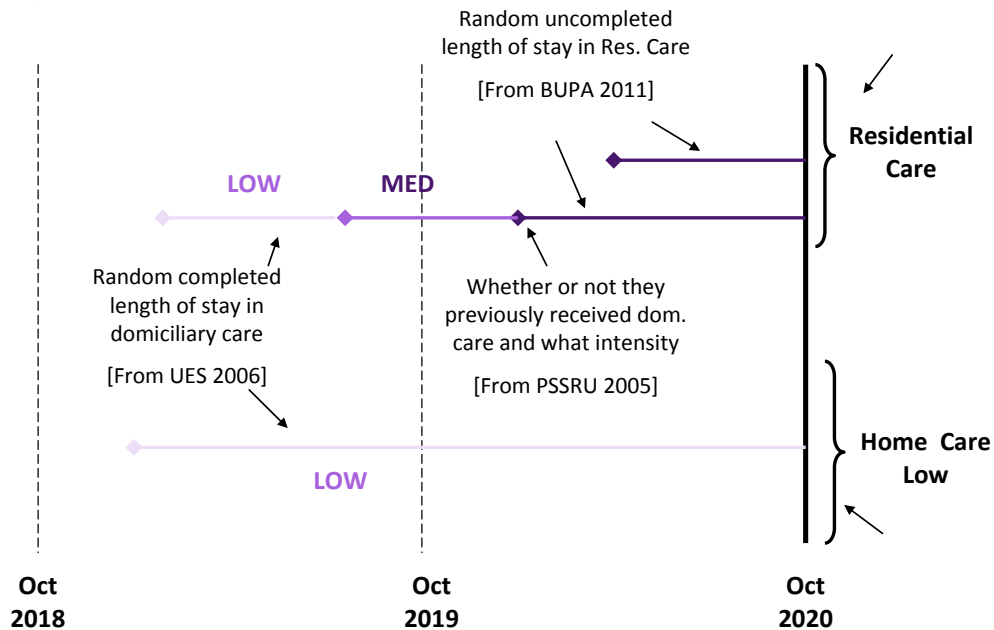
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[1] http://www.ifs.org.uk/ELSA

[2] PSSRU DP 2769 – Jan 2011 – Commissioned by BUPA

[3] PSSRU DP 2265/3 – July 2006

[4] User Experience Survey 2006

Figure 15: Modelling of uncompleted care journeys

Each person in care at the cross section is assigned a randomly assigned uncompleted care pathway

Random uncompleted length of stay in Res. Care

[From BUPA 2011]

LOW   MED

Residential Care

Random completed length of stay in domiciliary care

[From UES 2006]

Whether or not they previously received dom. care and what intensity

[From PSSRU 2005]

LOW

Home Care Low

Oct 2018   Oct 2019   Oct 2020

Assumptions in the PSSRU aggregate model

B13 The majority of the assumptions are relevant to the projections of future costs for the current system, as well as projected the increased spend of the reformed system. From the interaction with the PSSRU aggregate model these assumptions follow through into the projections of cost of the reforms.

B14 The key assumptions in the PSSRU aggregate model are:

KEY ASSUMPTIONS OF THE BASE CASE OF THE PSSRU MODEL
- The number of people by age and gender changes in line with the Office for National Statistics (ONS) 2008-based population projections.

- Marital status changes in line with GAD (Government Actuarial Department) 2008-based marital status and cohabitation projections.

- There is a constant ratio of single people living alone to single people living with their children or with others and of married people living with partner only to married people living with partner and others.

- Prevalence rates of disability by age group (65-69, 70-74, 75-79, 80-84, 85) and gender remain unchanged, as reported in the 2001/2 General Household Survey (GHS) for Great Britain.

- Home-ownership rates, as reported in the 2001/2 Family Resources Survey (FRS), change in line with projections produced by the University of East Anglia.

- The proportions of older people receiving informal care, formal community care services, residential care services and disability benefits remain constant for each sub-group by age, disability and other needs-related characteristics.

- Health and social care unit costs remain constant in real terms to 2015 and then rise by 2% per year in real terms (but non-labour non-capital costs remain constant in real terms).

<u>Sensitivities around modelling assumptions</u>

B15 In the developing the DH model there are some key assumptions, which are drivers of the cost of a capped cost model. They are:

- Proportion of self funders who would meet the LA eligibility criteria.
- Length of uncompleted care journeys in the model.
- Average residential care fee for state supported residents.

B16 We have performed sensitivity analysis around these 3 assumptions.

Proportion of self-funders who would meet the LA eligibility criteria

B17 An input to the DH social care funding model is the projected number of self funders under the current system from the PSSRU aggregate model. This projection is the total number of self-funders in residential care and is likely to include people who would meet their Local Authority's eligibility criteria. As our central assumption, we assume that 10% of the projected number of self-funders would be ineligible for state supported residential care on their assessed needs.

B18 Around this central assumption we present sensitivity analysis with a high scenario where 0% are ineligible and a low scenario where 20% are ineligible.

10/11 prices	*Impact of costs of reforms for older adults care in 25/26*	
Self Funders: Central assumption 10% of projected self funders are below LA eligibility threshold		£1.94 billion
High Scenario 0% of projected self funders are below LA eligibility threshold	+10%	+£190 million
Low Scenario 20% of projected self funders are below LA eligibility threshold	-10%	-£190 million

Length of uncompleted care journeys

B19 The derivation of the distribution of uncompleted care journeys used in the DH social care funding model uses the best available survey evidence from the English Longitudinal Study of Ageing. However, we recognise that the evidence of the nature of care journeys is an area where the evidence base could be improved upon.

B20 Around this central assumption we present sensitivity analysis with a high scenario where the derived distribution of lengths of the uncompleted care journeys are increased by 10%, and a low scenario where they are reduced by 10%.

10/11 prices	*Impact of costs of reforms for older adults care in 25/26*	
Care journeys: Central assumption Derived distribution of care journeys from most appropriate survey evidence		£1.94 billion
High Scenario Length of care journeys increased by 10%	+11%	+£200 million
Low Scenario Length of care journeys reduced by 10%	-5%	-£90 million

Average residential care fees for state funded residents in 2016/17

B21 We assume that the average residential care fee for state funded residents will be around £625 per week in 2016/17. Derived by uprating the unit costs of residential care as recorded in the "Personal

Social Services: Expenditure and Units Costs – England" publication[5]. If care costs are lower than this central assumption in 2016/17 then the costs of the reforms will be lower (and the cap will provide less protection), and vice-versa if the costs are higher.

	Length of stay in residential care to reach the cap	*Impact of cost in 2025/26 (10/11 prices)*
Care cost inflation: Central assumption 0% real to 2014/15, 2% real afterwards	3 yrs 5 months	£1.94 billion
High Scenario 2% real to 2016/17	3 yrs 0 months	+£330 million
Low Scenario 0% real to 2016/17	3 yrs 9 months	-£180 million

Sensitivities around future trends

B22 There are a further set of assumptions around the future trends of the key drivers of both the projections of the cost of the current system and the costs of option 1. We discuss these in turn:

- Unit costs of care.

- Population projections.

- Prevalence of disability.

Unit costs of care

B23 The central assumption on care cost inflation is an annual 2% real increase. This assumption applies to all components of care including residential, domiciliary, assessment, case management and review costs. This assumption feeds through from the PSSRU modelling of projecting the costs of the current system. Variation from this central assumption changes the cost of option 1 in the same way as the current system.

Change in 2025/26	*Current system*	*Option 1*
Care cost inflation: Central assumption 2% real		
High Scenario grow 1% more each year than central assumption	+12%	+12%
Low Scenario grow 1% less each year than central assumption	-9%	-9%

Population projections

B24 The central assumption PSSRU modelling of the current system uses the Government Actuary Department (GAD) central population projection. Variation around this assumption changes the stock of older disabled people. Variation from this central assumption changes the cost of option 1 in the same way as the current system.

Change in 2025/26	*Current system*	*Option 1*
Population projection: Central assumption GAD central		
High Scenario GAD high	+2.5%	+2.5%
Low Scenario GAD low	-2.5%	-2.5%

Prevalence of disability

B25 The central assumption in the PSSRU modelling of the current system is that age-gender prevalence remains constant. Variation around the central assumption changes the stock of older disabled

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[5] Personal Social Services: Expenditure and Unit Costs England, 2011-12 – Final Release – IC NHS

people and also the length of time they are disabled. The sensitivity to this assumption is greater for option 1 than the current system.

Change in 2025/26	Current system	Option 1
Disability prevalence: Central assumption Constant age/gender prevalence		
High Scenario Disability rates increase by 1% per year	+15%	>+15%
Low Scenario Disability rates fall by 1% per year	-15%	<-15%

B26 There are other assumptions that impact on the projected costs for the current system and option 1.

Trends in informal care: The central assumption is that the proportions of older people receiving informal care remain constant for each sub-group by age, disability and other needs-related characteristics. Variation away from this central assumption will impact on the projected costs of the current system and option 1 through more or less older people receiving formal services and therefore starting their progression towards the cap.

Patterns of care: The central assumption is that the proportions of older people receiving community care services and residential care services remain constant for each sub-group by age, disability and other needs-related characteristics. Variation away from this central assumption will impact on the projected costs of the current system and option 1 through a change in the average unit of care and changes to the individual's lifetime costs of care.

Eligibility for state support: The modelling assumes that local authority the proportion of self funders with eligible care needs remains unchanged. If there is any extension or tightening of eligibility thresholds potentially as a result of the setting of a national minimum eligibility threshold then this could have consequential cost implications.

Up-rating of cap over time: The modelling assumes that the cap is uprated in line with the assumption for care costs.

Reductions in disability benefits

B27 State funded care home residents have their Attendace Allowance (AA) or Disability Living Allowance (DLA) continued after 28 days of stay, under current practices. The reforms results in more care home residents becoming state funded, through the extended means test and cap on care costs. This results in a reduction in the numbers eligible for AA and DLA and therefore a cost saving. The same savings are assumed to apply to Personal Independence Payments (PIP) as they replace DLA over time.

B28 The estimates of the savings to disability benefits are estimated from the DH social care funding model estimate for the additional number of residential care residents who are state supported (either through the cap or the extended means test) compared to the current system.

Working age adults

B29 The DH analysis for working age adults takes estimates from PSSRU for the projected costs of the current system and of a "zero cap" option to produce an estimate of the cost of the reform option between the two bounds. These costs were produced using the PSSRU working age adult aggregate model.

B30 The PSSRU working age aggregate model projects the number of working age adults with disability split into 3 categories, those with learning disabilities, physical or sensory impairments and those with mental health problems, and the public expenditure to support these.

B31 The key assumptions are:

- The number of younger adults by age and gender changes in line with the Office for National Statistics (ONS) 2008-based population projections (GAD, 2009).

- Marital status rates for physically disabled younger adults change in line with ONS 2008- based marital status and cohabitation projections (ONS, 2010), while those for learning disabled people remain constant.

- There is a constant ratio of single people living alone to single people living with others.

- Prevalence rates of learning disability by age and gender change in line with the 'middle' projections of the future need for social care services among adults with learning disabilities by Emerson and Hatton (2008; Table 4)[6] and the prevalence rates of physical disability by age and gender remain unchanged as reported in the 1996/7 FRS.

- The proportions of younger adults receiving informal care, formal community care services, residential care services and disability benefits remain constant for each sub-group by age, gender, client group, disability and other needs-related characteristics.

- The real unit costs of social services and of Independent Living Fund payments remain unchanged to 2015 and rise by 2% per year in real terms thereafter. DLA rates remain constant in real terms and that future PIP rates are equivalent to current DLA rates.

- Real Gross Domestic Product rises in line with Office for Budget Responsibility assumptions (OBR, 2011).

- The supply of formal care will adjust to match demand, and demand will be no more constrained by supply in the future than in the base year.

B32 The upper bound estimate of free care for working age adults with eligible social needs modelled by PSSRU.[7]

10/11 prices	2010	2030
High Estimate	£500 million	£800 million
Low Estimate	£200 million	£300 million
Mid-point	£350 million	£650 million

B33 The off model analysis produces the cost estimate for option 1 less than this because those developing disabilities after the age of 40 will only receive free care after they have made some contribution to their care costs, up to a cap. The cap will be lower than the £72,000 for older adults but the level of this cap is yet to be determined. For the costs in this Impact Assessment, we have a modelled a tiered cap as recommended by the Commission for Funding Care and Support. We will be consulting around the final policy for working age adults.

Age group	Cap level modelled in 2017/18
<40	Free care
40-44	25,000
45-54	40,000
55-64	60,000

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[6] CeDR Research Report 2008:6

[7] Projections of Demand for Social Care and Disability Benefits for Younger Adults in England – PSSRU (October 2011)

Assessment, case management and review costs

B34 Under the current social care system, everyone is entitled to a local authority assessment. However there is little incentive for self funders to come forward. Under these proposals self funders have a greater incentive to come forward to begin their progress towards the cap.

B35 Based upon the PSSRU Aggregate Model and the work of the Commission on Funding of Care and Support we estimate that there will be an increase in the number of assessments (for new care users) of between 180,000 and 230,000 in 2016/17 and of reviews (for people already receiving care) of between 440,000 and 530,000 in 2016/17.

B36 We also assumed estimates of the increase in the number of reviews and care management costs. Once the percentage increase in the number of assessments was calculated, this was applied to the estimated total costs of assessment in the current system. This was done through using the PSSRU Aggregate model of the number of Local Authority supported individuals and an estimate of the unit costs of assessment.

B37 Two sets of unit costs for new assessments, care management and review costs were included - a low cost and high cost, since research demonstrated there was variation between local authorities. The estimated unit cost of assessment and review was calculated using information provided by local authorities. The estimated unit cost of care management was calculated by comparing the total cost of assessment and reviews with the reported total spend on Assessment and Care Management for Supported Older People provided by the Health and Social Care Information Centre. The remainder was divided by the number of supported people to give a unit cost.

	A	B
New Assessment	400	500
Review	200	250
Case Management	1117	996

B38 To calculate the central estimate of costs from the two methodologies and two sets of unit costs, we took the mid point between the highest estimate of the increase in assessment costs and the lowest estimate.

B39 The number of self funders likely to require case management was calculated from estimates for the number of self funders with high intensity domiciliary care needs. This is because most, domiciliary self-funders are expected to continue to purchase their own services and so would not require significant care management. However, it is possible that those with high intensity, complex needs will benefit from care management, even though they continue to purchase their own care.

B40 Using PSSRU aggregate output, we estimate that in 2010 there were 30,000 self-funding domiciliary care clients with high intensity needs. As a mid point estimate we have assumed that half of these high intensity users would take-up and benefit from formal case management techniques funded by the local authority.

B41 Through the consultation and engagement we will look to refine our understanding of assessment , review and case management costs, working with local authorities to increase the accuracy of these estimates and to minimise the burden these costs impose.